CO-OP / CONSUMER SPONSORED HEALTH CARE DELIVERY EFFECTIVENESS

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EXECUTIVE SUMMARY

In the face of continued rising costs of health care services, fiscal restraint, and relentless pressure to reform our health care policies and systems, governments all across Canada are keener than ever to introduce alternative cost-effective health care delivery models. In this study we assess the efficiency and effectiveness of the co-operative/consumer sponsored ("Community Participation") health care delivery models relative to other existing or proposed health care delivery models.

We found that community participation health care centres (CHC) offer significant economic and non-economic advantages. Their overall costs per patient are lower. They have consistently brought about significantly lower hospital utilization rates. Their emphasis on multi-disciplinary teams makes them better and more cost-effective users of health care professionals. Their drug costs per patient are lower than those under other delivery models. Patient satisfaction and quality of care in CHCs appear to be the same as for other models of health care delivery. The CHCs also offer relatively more preventive and health promotion services. They have an impressive record of innovations and improvements in making services more accessible to disadvantaged groups. They have also been successful in integrating health with non-health services. CHCs also allow a greater extent of consumer choice in decisions about health care services and definitely permit public involvement in the setting of priorities, operational policies, program planning and administration of the centres.

These advantages make such co-operative or consumer sponsored health care centres very good vehicles for carrying out many of the government health system objectives and priorities. Indeed, that is why they have been and continue to be strongly recommended by virtually all the commissions of inquiry over the past two decades. Many independent analyses have also recommended a rapid growth of such centres. However, except for Quebec and to some extent Ontario, the expected growth in community participation health centres in Canada has simply not occurred.

Among the reasons for the lack of growth are insufficient political commitment, inadequate funding, lack of legislative legitimacy of the centres, opposition by the traditional health care sector, the difficulty of attracting medical personnel, and the image of these centres as being the "poor peoples' health haven".

The reforms recommended include, among others, the need for governments to recognize through legislation that such centres are an important delivery model in the health care system. Legislation that sets out the CHC's role, its financial, organizational structures, accountability, and its operational principles and features is long overdue. Both the CHC and the governments need to market the concept of the CHC and counter its image as a poor people's health centre. As well, greater co-operation between the associations which represent these centres and the government in planning, adminstration, managerial and information systems development, and effective and timely evaluation of programs are advised.

We note that there are several co-operative/consumer sponsored (or community participation) models which are viable for meeting growing government priorities and objectives. Not every specific model would work in every community. The choice in each community will vary. Pluralism is unavoidable and even desirable, for the "best" model, in the end, is the one which best reflects the particular nature and needs of the community to be served. Rather than pursuing a specific model it would be better to ensure that the chosen model has certain important characteristics: (a) it should be relatively easy for providers to identify with their mission, goals and objectives; (b) financial and professional incentives to promote cost-effective use of resources; (c) decentralized decision-making which emphasises accountability and responsibility; and (d) provision of services which match patient needs with quality assurance mechanisms in place.

The Canadian Co-operative Association and the Conseil canadien de la coopération are urged to form alliances with provincial and national associations of CHCs, Local Community Services Centres (CLSC)s and even some health services organizations to make a common cause of the desired reforms which are needed. The central aim of such collaboration and co-operation is to promote the development of a community participation approach, rather than a specific model, to health care delivery in Canada.

It is recommended that funding commitments for capitalization of these alternative community participation delivery models be sought from governments and that either capitation or budget funding would be appropriate for the operational expenditures. The budgeting of these alternative community participation models need not involve new or additional provincial monies. It is advised that the funding be derived from a reduction in the annual percentage increases in existing health care budgets. In this manner, resources are shifted gradually over time from the acute and institutional sectors to those alternative delivery models. Several other reforms or changes might also be considered. For example, these community participation models of delivery should be permitted to market themselves in order to enrol more clients. Yet another example is to remove legislative and professional barriers so as to permit a wider and effective use of multidisciplinary teams.

The importance of government action and support cannot be overstated. Many of the essential steps which need to be taken to bring about a greater role for the community participation delivery models are the responsibility of the provincial government.

We are at a stage in history where all of the community participation models could have a major role in transforming the health care delivery system in Canada. The Canadian Co-operative Association and the Conseil canadien de la coopération could take a leadership role in this regard. This would be particularly important given the initiatives and leadership shown by the federal Co-operatives Secretariat and participating provincial governments.

CHAPTER 1: INTRODUCTION AND OVERVIEW

"As we broaden and deepen our understanding of health, we begin to perceive with greater clarity the importance and magnitude of the challenges now looming in the field of health. We also draw the conclusion that our system of health care as it presently exists does not deal adequately with the major health concerns of our time" (Epp:1986:4).

Over three decades have passed since universal health insurance was implemented in Canada. Overall, Canada's performance in providing universal and comprehensive medical and hospital services to all Canadians has been admirable. Compared to most other countries it is an effective system which has given Canadians what they seem to want at a reasonable cost. Yet, as is discussed later in this study, our system is facing some difficult challenges and, as a result, appears to be in a state of transition in an effort to redress some of its major flaws.

1.1 ELEMENTS OF THE TRANSITION IN HEALTH CARE

The broader definition of health is impacting on the whole health care sector. The public is assuming a more active and participative role, new health professions are emerging, the role of the health care professional is being modified to a more egalitarian, supportive and consultative role, the hospital (once again) is being viewed as a community resource, and governments are acting as facilitators of health promotion initiatives.

Traditional boundaries and relationships between the public, professionals, health care facilities and governments are being altered by the transition in the health care system (Siler-Wells:1988). Evidence of this change is demonstrated by the increase in self-help and mutual aid endeavours, partnerships in the personal management of health, closer working relationships between provinces and health care facilities. Boundaries are blurring and changing as well, for example, in the area of health education where health educators, nurses, physicians, pharmacists and nutritionists are all playing increased roles. Boundaries are changing between the traditional providers and new emerging practitioners, e.g., midwives, between physicians and nurse practitioners, between nurses and nurses aides. The requirement for multidisciplinary research is moving this function into new areas such as social change, the environment, recreation, urban planning.

Decision making and operational management are changing as well. Individuals are assuming more responsibility for lifestyle management. Governments and health care facilities are beginning to modify operating philosophies. The new philosophy is based on open and participative practices, increased coordination, integration and co-operation, and on clear missions, goals and objectives with which to assess efficiency and effectiveness of policies and programs.

The changing definition of health is responsible for the development of new, more complex models of health, as well as better ways of measuring and monitoring population health status. Governments and health care facilities are being forced to deal with these new and emerging elements in public attitudes, expectations and needs. One of the positive responses to these changes is the development of alternative models of health delivery.

While changes are occurring and new ways of doing things are being considered, a number of important conflicting values which affect the process of change are evident. For instance, as consumers we want access to all possible medical interventions, but as taxpayers we are not willing to pay taxes to ensure that these services and procedures might be widely available to the public. As a society, the reality of economic/fiscal constraints threatens society's ability to continue to provide the types of health care services to which we have become accustomed. In another area, as individuals we expect the health care system to "repair" us when we become ill, and to protect the environment in which we live. Yet, at the same time, we want the freedom to behave

irresponsibly in how we manage our own personal and community health. An additional conflicting value shows up in the area of local versus central control of health resources; while more and more studies are recommending decentralization of responsibility and accountability, control and management of the resources to achieve health still remain highly centralized. Finally, there is the strong conflict which exists between the need for reform and the persistent resistance to change. Major commissions have recommended shifting the focus of the health care system's primary mandate, yet the agents who have the greatest potential to change the system (professionals, institutions and governments) often act as the strongest resistors to change.

1.2 CONTEXT FOR CHANGING DIRECTIONS

It is important to understand the changes and paradoxes which exist in the transitions occurring in health and health care delivery, for they can affect the approaches to health the alternative models which communities may decide to adopt and implement. Out of all of this, two broad directions appear to be emerging. First, there appears to be a re-emergence of the informal health network in society, and second there appears to be a need for interventions which focus on "health".

If we define the health network as things we do, actions we take and places we are which enhance and preserve our health (in the positive sense), then the primary function of this network is to maintain and enhance our personal and collective health. The resurgence of social supports, e.g., self-help, mutual and, community support groups, friends, kin, neighbours, community activities and education, is evidence of the increasing importance of this health network. The gate keeper to the health network is the individual functioning on his/her own behalf, while in the health care system traditional access is gained through a physician visit.

The dynamics of the health care system and the health network differ in many ways. The health care system is formal, centralized, organized and based primarily on interventions by professionals. The health network on the other hand is informal, decentralized, non-organized and based on lay public interventions.

Both systems are necessary. While the health network is primarily concerned with health enhancement, the major raison d'etre of the health care system is sickness care. Their activities complement each other. In fact, the dynamics of the two systems (their boundaries and activities) often overlap and are interactive. Both systems are important to health. It would seem that a key function of viable, community participation models of health delivery would be to coordinate, link and possibly integrate these two systems.

Another important direction to consider in the context of co-operative/consumer sponsored health care delivery alternatives is the need for interventions which focus on the health context. If we define the health context as the physical and social environments in which people live, work and play, then we mean environments over which we as individuals have little direct impact or control. Rather, control has to come from public and private sector policies, programs and practices. While the evidence has shown, especially during the past few decades, that conditions in the health context are more significant determinants of health than is the health care system, we continue to focus (by and large) on health care system interventions which are aimed at individuals.

The focus of interventions in the health context is on community or societal levels, as opposed to the individual. Family structures, education, community activities, meaningful employment, work environment conditions, urban density, community pollution, poverty, inadequate housing, unemployment (and under-employment), support networks are examples of this important health context. Since governments, corporate institutions and communities create and modify health context conditions by their policies and actions, it is important that community/consumer-spon-

sored alternative health delivery models consider these elements in the development of mandates and range of services.

1.3 POTENTIAL FOR CO-OPERATIVE/CONSUMER-SPONSORED HEALTH CARE DELIVERY: OBJECTIVES AND SCOPE

Given that the health care system is in transition, that a number of changes are taking us in new directions, and if we want our health care system to be relevant and useful in the future, we will have to develop ways to incorporate a wide variety of health care delivery options in a cost-effective and efficient manner. It is likely that these changes will have to be within the context of reasonable access to quality care for Canadians, a key principle of Canadian health care policy.

As suggested above, it is being recognized that links between community resources and health care facilities are crucial to improving the delivery of health care. Integration of institutional and other health services with existing and new non-health community services has been an issue for at least a decade, particularly with respect to the delivery of services for children, the elderly, the disabled, and the mentally ill. Recently, we have been observing reductions in hospital lengths of stay and substitution of inpatient care with ambulatory treatment.

To adequately meet the pressures for change, community, institutional and social services which consider the determinants of health broadly, have to be coordinated and integrated within a region or municipality. This network would be able to respond to local needs and improve accessibility to services via a continuum of care (Manga and Muckle, 1986).

Consideration of viable alternatives for health care delivery is based on economic and non-economic reasons. In the face of harsh fiscal realities, governments are pushing for less expensive ways to deliver health services. There do not necessarily have to be any trade-offs between cost and quality of care in shifting to alternative ways of doing things. As might be appreciated in the health network (noted above), sometimes less expensive is better. Furthermore, if we are to effectively reduce inequities, increase prevention/promotion and enhance coping/managing effectively, as well as to "achieve health for all", we will have to establish a flexible continuum of care to meet people's needs for supports without creating unnecessary changes in their lives.

At the present time there are a variety of health care delivery models in Canada which could address the delivery of comprehensive preventive, primary, secondary and tertiary health care and related social services as alternatives to the existing system of medical and hospital services. One of these is the Co-operative Health Centre (COOP). All of them face a number of critical health and structural challenges. Furthermore, as governments consider seriously the implementation of alternatives to existing health care delivery, questions about the characteristics, strengths and weaknesses, relative merits, cost-effectiveness, etc. with respect to these options are raised.

At the beginning of 1990 the Canadian Co-operative Association, whose interests lie in the co-operative approach to health care, requested research proposals which would examine co-operative/consumer sponsored health care delivery effectiveness. The research objectives of the project were:

* to explore the viability and effectiveness of co-operative and consumer sponsored health care delivery in Canada; and,
* to prepare a descriptive report which illustrates the extent to which co-operative/consumer health care delivery implements national and provincial/territorial health legislation and health legislation policy priorities.

To respond to these research objectives we have reviewed the key alternative models of health care delivery and the past experience associated with these alternatives. We examined an

extensive series of published and unpublished documents and conducted a number of key informant interviews. With this in mind, the report is divided into sections dealing with a critical examination of the literature, assessing alternative models of delivery, relationships between various health care delivery models and government objectives and priorities, and the implications for reform.

While reading this report, it is essential to remember that the plethora of trends and pressures highlighted earlier represent an enormous challenge to the form and function of Canada's health care system, and it is expected that they will continue to do so during the next decade at least. Depending on the perspective taken, i.e., the glass is half empty or half full, these change forces can create both problems and solutions and can serve as opportunities or threats to the system. Furthermore, the impacts of these pressures include challenges to the traditional roles within each group of key players in the system and the emergence of new roles. A major challenge facing decision makers in the health care sector is the extent to which the trends and forces are translated into effective policies and programs.

CHAPTER 2: A BRIEF REVIEW OF THE EMPIRICAL LITERATURE

2.1 INTRODUCTION

There are few evaluative studies of the performance of co-operative/consumer sponsored health care delivery systems relative to other models of delivery, principally, the fee-for-service solo practice. There are more studies of health care delivery systems similar in some significant respects to the co-operative/consumer model, such as the community health centres, health services organizations, CLSCs, and health maintenance organizations. In what follows, we present the major findings and conclusions of these studies. It is not our intention to comment in detail about research design and methodological issues unless it is strictly necessary for interpreting the results. While any empirical study in this area has some methodological, statistical or analytical weaknesses, or resort to assumptions, we offe findings and conclusions we believe are defensible and supportable.

2.2 MAJOR COMPARATIVE FINDINGS AND CONCLUSIONS

The co-operative, consumer sponsored community health centres, and similar such health care delivery models are generally found to be cost-effective relative to fee-for-service practice. We have not encountered a single study that demonstrates the contrary.

In a methodologically sound study, an evaluation of Saskatchewan's two largest community clinics was undertaken. The costs of health services of 15,297 community clinic users were compared with those of 15,297 private practice patients. The groups were matched in terms of geographic area, age, sex, marital status, family size, family type, social assistance status and registered Indian (treaty) status since these characteristics could have a significant effect on health care utilization differentials. With regard to the total cost of health services, the per capita costs were 13 percent lower for the clinic patients in Prince Albert and 17 percent lower for clinical patients province-wide compared to their private practice counterparts (Saskatchewan Health, 1983, Table 26, 74). We cannot resist pointing out that while this study was completed in 1983 "the government steadfastly refused to release the results. Finally, in the late summer of 1989, after many requests from the community clinics and... after the matter was raised repeatedly in the Provincial Legislature the Minister of Health authorized the release of the report" (Marwick, 1990, 8). It is symbolic of the political, economic and related health policy issues that surround the role of the co-operative or community health centres in Canada.

The principal reason for the overall cost-effectiveness of the community clinics is the significantly lower hospital utilization of clinic clientele compared to those of fee-for-service practitioners. This is the most common, and from the standpoint of the economics of alternative delivery modalities, the most significant and incontrovertible finding of the numerous empirical studies we reviewed. In the Canadian health care system "decreased hospital utilization is the major source of improved cost-effectiveness" (CHEPA, 1986, 3). The not fee-for-service modalities (i.e. capitation, fixed budgets, salary) have been shown over and over again to generate rates of hospital utilization from 10 to 40 percent below fee-for-service physicians (Evans, 1984).

In the aforementioned Saskatchewan study, the Prince Albert clinic patients had 23 percent fewer inpatient days, 10 percent fewer separations and an average length of stay that was 15 percent lower than that for private-practice patients. Overall, their inpatient costs were 23 percent lower than the hospital costs for a comparable group of private patients. In Saskatoon, clinic patients had 31 percent fewer inpatient days, 21 percent fewer separations, 9 percent shorter average length of stay and 30 percent lower hospital costs than the private-practice patients. The lower utilizations occurred for males and females in most age groups (Saskatchewan Health, 1983, 72). The clinic patients had lower admission rates for both urgent and elective admissions (Saskatchewan Health, 1983, 72). It is noteworthy, given our rapidly aging population, that the

biggest difference in hospital utilizations occurs in the older age groups, especially those over 65 years of age (Saskatchewan Health, 1983, 33). Furthermore a later study confirms these general findings. An analysis of the 1984-85 hospital utilization data in Saskatoon indicates that clinic patients had a 23 percent lower hospital use than private-practice patients (Apland, 1989, 21-22).

These findings are hardly new for the province of Saskatchewan. An earlier study of the three largest clinics in Regina, Saskatoon and Prince Albert showed that clinic patients had consistently and significantly lower rates of hospital utilization than patients receiving care from other physicians in the same community. The difference, after age-sex standardization, was 25 to 30 percent fewer patient days, and 19-23 fewer separations. The clinic patients also had lower average lengths of stay of about 5 percent. That is, most of the difference was accounted for by a lower rate of separation in each community. The study also estimated that the lower hospital use could generate a savings in hospital costs of about 15 percent (McPhee, 1983, 25). The study also attempted to find an explanation for these differences and concluded that the "entire form and nature of physician practice in the clinics results in lower hospital utilization" (McPhee, 1973, 1). In other words it could not isolate any one specific factor such as general practitioner versus specialists, place of graduation, age of physicians, and so on.

Further confirmation of these findings can be found in several studies of Ontario community health centres and health service organizations. The Sault-Ste-Marie Group Health Association shows a per capita lower costs of 25-30 percent on an age/sex adjusted basis relative to private practice patients (Rachlis and Kushner, 1989). The reasons for the lower hospital costs and utilization is due to "ambulatory investigations, early discharge options, day care surgery and other (health and social) programs" according to Fred H. Griffith (1987, Keynote address, June 11). The Association of Ontario Health Centres has reported lower hospital utilization for community health centres and health service organizations for several years. The latter delivery system has had a 20 percent lower hospital use rate compared to the other residents in the same localities for each of the years 1984/85 onwards (AOHC, 1989, 1). "Enrollees at community-sponsored Health Service Organizations (HSO)s showed a 30 percent lower use. These centres as a group have the broadest range of non-medical services. Physician-sponsored centres (HSOs) followed with 20 percent lower use, and family practice units, where they tend to see people with more complex illnesses, shows a 10 percent lower use" (AOHC, 1989, 2). The principal reason for the lower use of hospitals by HSO patients is the lower rate of admissions. They are 15 percent lower than fee-for-service patients, whereas the average length of stay is just 5 percent lower for HSO patients. Poignantly, the AOHC suggested that these figures indicate a significant savings in future bed use and construction. It should be further noted that the "HSO rate of hospital utilization is falling faster than in the fee-for-service sector".

Earlier Ontario studies too showed that the Sault-Ste-Marie Group Health Association patients used significantly fewer hospital services than patients of private-practitioners (Hastings et al, 1982; Mott et al, 1973; DeFriese, 1979). Similar findings were also made for the St. Catherine Clinic, though in this case the lower hospital use rate was largely due to shorter length of stay rather than lower admission rates. We note some further evidence that community clinics have lower hospitalization rates than either the solo practitioner or the physician sponsored and organized group practice (Ruderman, 1974, i). In Ottawa, the Sandy Hill Health Centre has a 20 percent lower hospital inpatient days than a comparable group in the geographic area of Ottawa-Carleton (Conlon, 1989, 12). Earlier recognition and treatment of disease and the integration of health and social services to permit continuity of care are among the factors often cited for the lower hospital utilization rate.

In the United States there are many models of health care organizations as alternatives to the fee-for-service practice. They serve a much larger percentage of the population than community centres, health service organizations and similar organizations do in Canada. We note briefly that enrollees in pre-paid group practice Health Maintenance Organizations had 35 percent lower rate of hospital use than their fee-for-service counterparts (Luft, 1981). In the

Rand Health Insurance Experiment, the Health Maintenance Organization (HMO) did even better, achieving a 40 percent lower hospital use (Manning et al, 1984). The much greater figures in hospital reduction in the U.S.A. by HMOs may be due to the greater incentives to save, healthier HMOs populations, full range of services and the vertically integrated nature of the HMO in contrast to the alternative delivery systems in Canada (Lomas and Stoddart, 1988).

Of course, a 10 percent reduction in hospital utilization does not translate into a 10 percent reduction in hospital costs. Barer (1981) estimated that a 20 percent reduction in hospital inpatient days leads to a saving of 5 to 8 percent in hospital costs. Part of the difference is accounted for by the increased need for community and ambulatory services. Much of the difference is due to the fact that unless hospital bed capacity is reduced in concordance with reduced admission rates and length of stay, the "empty bed" will inevitably be filled with other patients. Even such savings are not trivial but they could be considerably increased if, and perhaps only if, the government authorities reduce the hospital bed capacity relative to population over time. In other words the reductions in hospital utilization shown to date have a major potential for reducing the longer term growth in hospital costs.

The Saskatchewan study mentioned above found that the Saskatoon and Prince Albert clinic patients used lower number of services from general practitioners and specialists than did patients of the fee-for-service medical practitioners. Paradoxically, because of the various assumptions the study made in costing the medical services, it found that clinic patients incurred higher costs. The average cost per person in the Prince Albert clinic was 16 percent higher and in the Saskatoon clinic it was 20 percent higher (Saskatchewan Health, 1983, Table 5, 26). It also claimed that "not too much weight can be placed on the exact numbers of services" (Saskatchewan Health, 1983, 27). The earlier study by McPhee concluded that both the volume and cost of physician services is similar for patients receiving services from the clinics and other patients in the same community (McPhee, 1983, 30).

We note that the methodological, estimation of costs, and statistical problems are more severe when comparing the use of physician services between the different delivery modalities than for other health care services. Indeed, Hastings et al (1973) had great difficulty in determining the medical services utilization rates. Mott et al (1973) and De Friese (1974) found comparable rates in their studies of the Sault-Ste-Marie Group Health Association. In a recent critical review of the literature S. Birch and J. Lomas (1990) concluded that "the number of ambulatory service per patient (and) the total costs of ambulatory care were... likely to be similar" (Birch and Lomas, 1990, 5). It might be noted that in the U.S. patients of pre-paid group practice HMO use the same volume of ambulatory care as fee-for-service patients (Luft, 1981; Manning et al, 1984).

Even if the medical cost per patient were higher for clinics - a result we do not necessarily share - it is a small price to pay for achieving the much larger saving in hospital costs. The style of medical practice in community health centres may well result in a higher cost per visit than under fee-for-service practice. There may be a substitution of physician services for hospital and other care in community clinics, though we have no evidence of this, but offer it as an explanation for the findings of the Saskatchewan study.

Are patient loads of clinics or health service organizations higher than in the fee-for-service sector? One would assume so but this matter is often overlooked in the extant studies. Lomas and Cushman (1984) made various estimates of physician to population ratios of all HSOs in Ontario for 1982-83 and found that they use 22 percent fewer general practitioners and about 40 percent fewer specialists. HSO doctors have greater patient beds, thus fewer physicians would be required if there were more HSOs in Ontario. In the U.S.A., HMO physicians service more patients (Manning et al, 1984; Steinwachs et al, 1986), giving further support to the view that non-fee-for-service modalities have greater patient loads. The distribution and oversupply of physicians in urban areas is a problem common to most of Canada and contributes to the problem

of falling patient loads and high health care costs. It is also an obstacle to the effective utilization of less costly health personnel.

With regard to the latter point, Mitchell (1984) has suggested that fee-for-service physicians are very concerned about the encroachment of their professional turf by other health care personnel. By contrast, community clinics across the country have had considerable success in making greater and more effective use of nurses, nurse-practitioners, mid-wives, physiotherapists, occupational therapists and nutritionists (Kagis and Muckle, 1987, 32), and they have consistently emphasised a multi-disciplinary approach to service delivery (Marwick, 1990). In a recent study Lomas and Abelson (1988) show that HSOs in Ontario are more likely to employ a nurse practitioner than either solo or group fee-for-service practices. They also show that community health centres use more non-physician health personnel than HSOs (and, of course, fee-for-service practices). Notably, the community health centres were more likely to use nurses and nurse practitioners for preventive screening services. In a Quebec study, the CLSC doctors were much more positive about working in multi-disciplinary teams than doctors in other practice settings. Manpower substitution and more generally the more effective use of health care professionals is an, if not the most, important avenue for improved efficiency in the health care system. A reduction in costs of up to 40 percent is possible in some forms of manpower substitution (Evans, 1984). Since the health care sector is inevitably labour-intensive, the community health centres offer a significant potential for efficiency gains in the delivery of health care services.

Most studies were not able to make definitive and often not even tentative conclusions about the quality of care given to patients in the different delivery modalities. Quality of care is difficult to define and operational measures to date are few and partial. In an earlier study, De Friese (1975) found that female patients of the Sault-Ste-Marie Centre were more likely to have had a comprehensive examination than their fee-for-service counterparts. (Incidentally, the Centre now has the Women's Health Centre affiliated with it). In a Ministry of Health study of the quality of care for six "tracer" conditions (ambulatory diabetes, institutional diabetes care, cholelithiasis, myocardial infarction, well-baby care and perinatal care) the St. Catharines Centre did better than the fee-for-service sector (Birch and Lomas, 1990, 7). In several studies, the CLSCs in Quebec were shown to provide better quality of care for patients with headaches (Renaud et al, 1980), more complete childhood immunization (Allard et al, 1985); more appropriate cancer screening (Battista, 1983) and better cancer prevention services (Battista et al, 1986).

Quality of care studies are more common and generally more rigorous in the U.S.A.. Several studies (Brook et al, 1982; Ware et al, 1986; Sloss et al, 1987) suggest that there are no differences between HMOs and fee-for-service physicians. Several studies show that non-profit HMOs do not compromise on quality of care, allegations to the contrary (Francis et al, 1984; Yelin et al, 1986). Nor is there any evidence in Canada that HSOs or community health centres provide lower quality of care than fee-for-service physicians. There is a paucity of studies comparing quality of care between different modalities in Canada.

In Saskatchewan, an analysis of the prescription drug plan utilization showed that for elderly patients, physicians in community clinics prescribed fewer prescriptions and that their prescriptions entailed a lower drug material cost than fee-for-service practitioners (Saskatchewan Health, 1983, 73). The Prince Albert clinic patients had 8 percent and Saskatoon clinic patients had 21 percent fewer prescriptions than their private-practice counterparts. Furthermore, the drug material costs were 11 percent (Prince Albert) and 21 percent (Saskatoon) lower for clinic prescriptions than private practice prescriptions (Saskatchewan Health, 1983, Table 28, 75). Fewer, more appropriate and less costly prescriptions, especially for the elderly, has both health status and economic advantages in light of our current concern about the rising cost and the misuse of pharmaceuticals.

Other efficiency advantages are also claimed for community clinics. For instance, "the provision of out-patient and support services (x-ray, laboratory, physiotherapy, etc.) through

community clinics can often be substantially less costly than provision of the same services through hospitals. The effectiveness of community clinics in this respect has been demonstrated many times in many studies undertaken by governments and by the clinics themselves" (The Community Health Co-operative Federation, 1987, 7).

To our knowledge no study has attempted to compare the relative costs of providing emergency services through community clinics, HSOs, CLSCs on the one hand and hospitals on the other. A study of this nature would be of considerable interest given the current concerns about the misuse of emergency services, rising costs and the duplication of services. The possibility that clinics may offer greater accessibility, lower costs and permit the rationalization of hospital emergency services has been suggested (Kagis and Muckle, 1987).

Community Health Centres have a clear and distinct advantage over fee-for-service delivery modalities in providing prevention and health promotion services. We cite just a few illustrative examples. The Sandy Hill Health Centre in Ottawa provides an occupational health program. The South Riverdale Community Health Centre in Toronto made a major contribution in the successful clean up of lead pollution in the local area. The Saskatoon clinic produced and distributed a pamphlet on "Staying Healthy: A Preventive Health Maintenance Package for Women 45 to 64 Years". Later it undertook an outreach program to reach women of lower socio-economic status (Apland, 1989, 16). Many community health centres offer prenatal educational programs; senior's self-help programs; stress management; information packages on a variety of health concerns including birth control for adolescents; counselling for victims of family violence and sexual assault; screening programs for breast and cervical cancer; preventive and educational programs for drug and alcohol problems; and counselling and social work services for the mentally ill and disabled. There are indeed other programs some clinics run for the elderly, rural populations, native populations, women, and immigrant or ethnic groups.

In Ontario, both the community health centres and the HSOs are more likely to have recall systems for pap smears and immunization than fee-for-service physicians (Lomas and Abelson, 1989; Vayda, 1988). The physicians in the HSO and the community health centres agreed that their style of remuneration (capitation, salary) favoured the delivery of preventive services. The fee-for-service physician felt that fee schedules did not encourage the delivery of such services (Lomas and Abelson, 1989). In Quebec, CLSCs are said to offer more appropriate and better cancer screening services (Battista et al, 1986, Battista, 1983) and a more complete range of immunization against childhood diseases (Allard, 1985). In the United States, Manning et al (1984) found that HMO patients received more preventive services than patients of fee-for-service physicians.

Comparison of patient satisfaction with the different modalities of care is, like the quality of care, not frequently done, and if done, not conclusive or unambiguous. Overall, there were few differences in patient satisfaction between clinic and fee-for-service patients in the Saskatchewan study frequently cited above (Saskatchewan Health, 1983, 79-80). Another set of observations suggests ambiguous results for Saskatchewan clinics. This "89 percent of those polled in a recent member survey provided a good or excellent rating of the services provided by the Health Centre (clinic) and 20 out of 23 new patients chose to stay with the Centre" (Ketilson, 1985, 37). Since there are no comparative figures for fee-for-service practice such data are not very meaningful. Kettilson (1985, 37) also states that "high turnover rates among physicians do lead to dissatisfaction". Mott et al (1973) and De Friese (1975) state that patients are less likely to see the same physician for all episodes of care than private practice patients. However, clinic patients were likely to be more satisfied with (less) waiting time to see a doctor, greater convenience for laboratory or x-ray testing, parking and related logistical aspects of care. From the foregoing, it would seem that except for seeing the same physician, community clinics offer aspects of care with which patients are relatively satisfied. Should community clinics reduce their physician turnover in the future - now more likely than in the past - the one aspect of their delivery that patients are less satisfied with than patients of private-practitioners can be resolved. This

problem should, however, not be overstated or overestimated. It, after all, is counterbalanced by the better hours of operation of clinics and easier and more convenient referrals.

There are very little empirical data on the extent or degree of patient participation or involvement in the care they receive. A Quebec study suggests that CLSC physicians were more receptive to patient involvement in their care than fee-for-service physicians. The more valid and interesting evidence based on patient opinions does not exist. Given the basic principles and philosophy of community clinics, their emphasis on patient education, service to marginalized and disadvantaged groups, belief in holistic health care and the decentralization of medicine, one would expect consumer participation to be greater in clinics than in fee-for-service practice. There is, however, no empirical evidence to support this expectation, nor for that matter, the reverse.

With respect to community involvement in the planning, management, administration and the setting of priorities no comparison can be made between co-op or community clinics and the fee-for-service sector. For the latter, such matters are impractical or non-issues by the very organization and the ethos of independent and autonomous practice. Most community health centres are sponsored and managed by an incorporated non-profit community board which is directly accountable to the public. Very few HSO are controlled by community boards. Board duties include the appointment of the executive coordinator (or director), the establishment of the mission statement, goals and objectives of the centre, and its policies and priorities. Its most important function is to direct the centre to meet the needs and expectations of the community. They have endeavoured to be broadly representative of their communities. In those centres where the members elect the Board of Directors, there is an obvious formal mechanism for public participation in decision making. In most centres the ultimate power regarding decisions about medical practice rests with the physician groups, and conflicts between the community boards and doctors are not uncommon (Kettilson, 1985). Community boards do have conflicts with physicians, local and provincial politicians, they are somewhat fractious - not always an unhealthy development - and may reflect community interests and composition with varying degrees of accuracy (Young, 1975; Lomas, 1985; Leseman, 1981; Godbout, 1981). However, the community health centres offer a more effective and meaningful public or consumer control of their operations than any other health care delivery organizations. Community involvement is more likely to result in services that respond to the real needs of the clientele as identified by the clients. In some jurisdictions, this is assured because a needs assessment study is required for government approval of new community health centres. Community health centres permit the expansion of democratic and patient rights in areas of health governance, planning and policies.

There are potential economies in the administration of health care delivery organizations. Most community health centres in Canada have professional administrators with a business or health administration training whereas this is uncommon in HSO or other private fee-for-service practice, whether solo or group. Only two physician sponsored centres in Ontario out of more than thirty have professional administrators (Conlon, 1989, 13). At a recent policy workshop on the status of alternative delivery modalities in Canada it was noted that "the importance of the internal management structure of alternative delivery modalities should not be underestimated, even though it is difficult to isolate its contribution to improved cost-effectiveness...common elements of this structure include peer review mechanisms, management information systems, clinical guidelines, and the use of...non-clinician management specialists" (Lomas and Stoddart, 1986, 3). We note that these features are simply non-existent or cannot be effectively applied in the fee-for-service practice settings.

One of the more significant differences between the various delivery modalities is the incentives generated by the method of physician payment. There is an extensive literature on the subject of the relative merits of capitation, salary and fee-for-service methods of paying doctors. There is considerable Canadian and foreign empirical evidence on the effect of the different methods of physician reimbursement that we refrain from citing or summarizing at this point.

For illustrative Canadian studies, Evans (1981) and Barer et al (1981) might suffice. These and other studies contain many comparisons that are pertinent to our concerns in this respect. The dominant conclusion of several critical evaluations of this literature is that the capitation method of paying physicians generates incentives for more efficient use of resources and that the fee-for-service method, conversely, leads to over servicing of patients (in the form of unnecessary visits and hospital admissions, more intensive servicing, excess referrals, patient sharing). These differences are more noteworthy and significant in the context of universal coverage like Medicare in Canada, and possibly a relative oversupply of physicians. The fee-for-service method also inhibits health manpower substitution. The insistence by co-op and community health centres on salary or capitation methods of paying physicians and multidisciplinary teams to deliver service is thus interrelated and necessary. These advantages are over and above the social and political costs involved in the frequently difficult and acrimonious bargaining over changes in the fee schedules, threats and sometimes the execution of strikes by fee-for-service practitioners, difficulties for the government in controlling physician costs and attaining a proper supply and distribution of physicians.

By contrast, budgeting and hence cost control for community health centres is relatively less problematic and offers many advantages. Budgets are negotiated and the cost of care is known to the government (unlike the fee-for-service sector). Service increases over the year are usually absorbed by the centres. Not only budgeting but the planning process is facilitated by the generally high level of co-operation and compliance by the centres to government requests for information. A management information system is relatively easier to implement in community health centres and should facilitate the monitoring of costs and utilization. Programmes implemented through the centres can be controlled and evaluated for their cost-effectiveness. Unlike the fee-for-service practice, the auditing of community health centres is an accepted practice which again should enhance the planning and evaluation of resource use by the centres. Community health centres not only do not resist evaluation of their programmes and services, but welcome and encourage the provincial governments to adopt evaluation criteria for purposes of program evaluation, budgeting and resource allocation.

Apland (1989) has noted that numerous commissions of inquiry in Canada have recommended both greater participation and involvement by consumers and decentralized planning. These are often repeated and reasonably based goals of health policy and health care organization. The rationalization of health care services, especially hospital and related institutional services, remains an important but elusive goal. It is possible to decentralize the planning, administration and the delivery of health care services (Manga and Muckle, 1986; Rachlis and Kushner, 1989). Apland (1989, 8) responds that "the co-operative model is decentralized and community-sponsored" (emphasis in the original). Community health centres in Canada have exhibited a keen interest and involvement in regional and community planning and have attempted to help in efforts to rationalize the non-institutional sector. They are strong supporters of District Health Councils (or similar planning organizations in other provinces), Social Planning Councils or similar local and regional planning bodies.

The last point brings us to yet another major difference between co-operative or community health centres and other health delivery models. Community health centres have a commendable history of involvement with a wide range of non-medical services and constitute a natural mechanism for facilitating the integration of health and social services needed by an increasing proportion of the public. One of the major reasons for the failure of the deinstitutionalization policy in several jurisdictions is the lack of integrated community-based services. Virtually all centres or CLSCs can demonstrate the selective integration in response to their communities' needs. HSOs do not attempt much of the desired integration, and fee-for-service private practitioners make even less of an effort, if any. For co-operative and community health centres the integration of health and social services (and indeed others as needed including housing, education, legal) is very much related to their orientation towards a more holistic approach to health as opposed to simply a medical model; their effort to improve the accessibility to services

to otherwise disadvantaged and marginalized groups; and their focus - though by no means exclusive - on those population groups that need an integrated or constellation of services not readily accessible or available from the other health care delivery modalities. Every community health centre is engaged in community networking and participates in many other organizations delivering health or social services. For example, the Community Health Services Association (Regina) Ltd. participates in more than 20 organizations (1989, 6-7). Another indicator of the level and range of integration these centres have brought about is the impressive range of treatment, health promotion, and prevention services they offer. Their emphasis on primary health care is, of course, obvious and justified. The increasing integration of health with other services forged in community health centres arose from their innovativeness and their mission to improve accessibility to primary health and social services to socio-economic population groups who are not necessarily well served by other health care delivery modalities. We suggest that the innovativeness of community health centres, the improvement in the accessibility to services, and the integration of health, social and other community services form a service syndrome or package that other health care modalities cannot and may not even be very interested in delivering.

The innovativeness of co-operative and community health centres have been documented by several provincial associations representing them, in briefs to recent commissions of inquiry looking at effective reforms of the existing health care system and health policy. The Prince Albert Co-operative Health Centre serves its elderly patients with a visiting nurse program. It also operates a minor surgery program. Community clinics in Regina and Saskatoon experimented with a chiropody program because the demand for foot care, particularly for the elderly, was high yet not covered as an insured benefit under the existing health insurance plans. Its success led to the implementation of a province wide chiropody program in 1984. A more dramatic illustration of innovations is the drug scheme begun at the Saskatoon Community Clinic in response to patients' concern about the cost of drugs. Patients could obtain high quality drugs at cost plus a small dispensing fee. This experience led to the Saskatchewan Prescription Drug Plan. The CLSCs in Quebec, it was noted earlier, have well organized cancer screening programs. An Ottawa community health centre established an occupational health program. In Winnipeg, the Health Action Centre provides a geriatric day hospital program. In Halifax, the North End Community Clinic offers dental care services to its members. Several clinics have programs for populations in adjacent areas, either rural populations or inner city neighbourhoods. There are numerous other examples of innovative programs for the elderly, women, adolescents, ethnic minorities and low income populations that could be cited as well. The innovativeness is derivative of the basic prospectus of community health centres, specifically, a community-based democratically controlled clinic is more likely to be responsive to the needs of its members, especially, but not only, those needs that are not adequately met by other sources of care.

The above also suggests that co-operative and community health centres are likely to make more and a wider range of services accessible to groups who would otherwise receive inadequate or even inappropriate care. The centres are widely acknowledged to improve access to health and social services to ethnic minorities, the poor, immigrants, native peoples, and other disadvantaged socio-economic groups. In Saskatchewan, the clinics have shown considerable success in improving accessibility to services to rural populations (The Community Health Co-operative Federation, 1989). Most centres throughout Canada have responded positively to the social and health needs of the elderly, and many can be characterized as having "a solid record in programming and services aimed at senior citizens" (Marwick, 1990, 11). This can be said of health and social services aimed at women as well. The existence of Women's Health Centres, such as the one in Winnipeg or in Sault-Ste-Marie or those in Quebec does not gainsay this judgement. The Women's Health Centre is based on similar orientation to health and social services, organizational principles such as community and patient involvement, non fee-for-service payment methods, insistence of multi-disciplinary team work and non-profit operation (Harris, 1989). Such centres developed in response to the dissatisfaction with the existing mainstream delivery of health care for women (Edginton, 1989; Dubois, 1988; Hancock, 1987; Simmons et al, 1984). The success of the community health centres in improving the accessibility to those who are not

well served by the other existing delivery systems has had an unfortunate and paradoxical consequence. They have an "image" problem and are often portrayed as a "poor person's health haven". They are often not considered an alternative source of primary health care by the majority of middle or higher income groups. This is, by no means, the only or even the principal reason for the lack of growth of co-operative or community health units. This is an issue we discuss later in Chapter 4.

CHAPTER 3: ASSESSING ALTERNATIVE MODELS OF DELIVERY

3.1 INTRODUCTION

While Canada can be proud of her past achievements in the delivery of health care services, there is rapidly mounting evidence which suggests that our highly-acclaimed system of hospital and medical services does have some flaws, e.g., lack of social support base, little emphasis on prevention and promotion, and an overuse of acute care beds. We are facing some pressures and challenges, e.g., an aging population, technology diffusion, supply and distribution of health professionals, changing health problems, public expectations, funding, organizational and reimbursement structures.

In our existing system, missing (in large part) are the linkages among the different components and the health care providers which would allow for integrated and coordinated health care. As a result, more people than is necessary end up being treated by the acute care system for problems which could be handled more effectively and efficiently elsewhere.

During the past few years, these various financial, organizational, social and political pressures have obliged many provinces to review the cost effectiveness and efficiency of health care. There is a significant degree of similarity among the provincial health care reviews, both in terms of the issues identified and the general strategies recommended and (in many provinces) being implemented which would take Canada's health care system into the next century. There is noticeable organizational restructuring, health planning and funding innovation. The basis for these reforms is a concern to rebalance and redirect the system in three important ways: towards greater emphasis on disease prevention and health promotion, towards community-based care alternatives, and towards greater accountability.

It is one thing to suggest that the existing system should be restructured and that future planning and delivery of health services will have to be different from that which they have been in the past. It is quite another thing however, to determine which alternative(s) would best address the needs of the population and current (and expected future) requirements of policy makers in an efficient and effective way. Depending on these factors, there are a number of health care delivery models which could reasonably fulfil a number of important expectations. In this chapter, we examine these various "models" in terms of a number of essential criteria, among which some of the most important are government policies and priorities, population needs and expectations, and quality of care. Inherent in these policy directions are cost-effectiveness, efficiency and equity.

Since one of the important distinguishing characteristics/policy priorities is a "community based/consumer sponsored/co-operative" orientation, the models discussed below are grouped into three major categories: community participation, quasi community participation, and minimal community participation. Models in each of these categories are examined, assessed and compared to Co-operative Health Centres (COOPS) from the perspectives of: organizational and managerial aspects (including the extent and nature of consumer participation, and funding arrangements), range of services provided, accessibility, quality of care, economic performance (including utilization rates, efficiency and effectiveness), and implementation efficacy with respect to government policies and priorities.

3.2 OVERVIEW

We use this section to overview the strengths and weaknesses of various models of health care delivery (Table 1 presents this information). For each of the key criteria we attempt to "pass judgement" on each of the models relative to the Health Co-operative Model (COOP). The sections following the matrix display discuss these characteristics in greater detail.

Table 1 : Synthesis of Criteria Attributable to Alternative Health Care Delivery Models

	Community Participation Models			
Criteria	CHC	CLSC	OSIS	COOP
A. Organization and Management	M	M	–	M-H
: Community Participation	M	M	–	M-H
: Funding Flexibility	L-M	M	M	M
B. Range of Services	M-H	M-H	M	M-H
C. Accessibility	M	M	–	M
D. Quality of Care	M-H	M-H	–	M
E. Economic Performance	M-H	M	M	M-H
F. Implementation Efficacy	M	M	–	M-H
: Shift the System	M-H	M-H	M-H	M-H
: Linkages	M	M	–	M
: Community-Based	M	M	–	M-H

Table 1 : Synthesis of Criteria Attributable to Alternative Health Care Delivery Models

	Quasi Community Participation Models			
Criteria	HSO*	HMO	CHO	MULTIS
A. Organization and Management	L-M	M	L	L-M
: Community Participation	L	L-M	L	L-M
: Funding Flexibility	M-H	M-H	M-H	M-H
B. Range of Services	L	M	L-M	L-M
C. Accessibility	L-M	L-M	L-M	M
D. Quality of Care	L-M	–	L-M	–
E. Economic Performance	M-H	–	M-H	–
F. Implementation Efficacy				
: Shift the System	M-H	M-H	M-H	M-H
: Linkages	M	M	M	L-M
: Community-Based	L	L-M	L	L-M

* While most of the HSOs are "quasi" in nature, there are three which would easily fall into the full community participation category. Many could be categorized in the "minimal" category.

Legend: (H) High, (M) Medium, (L) Low, (–) Unable to say anything

Table 1 : Synthesis of Criteria Attributable to Alternative Health Care Delivery Models

	Minimal Community Participation Models	
Criteria	HOSP	PHYS
A. Organization and Management	L-M	L
: Community Participation	L	L
: Funding Flexibility	M	L
B. Range of Services	L-M	L
C. Accessibility	L-M	L
D. Quality of Care	L-M	L
E. Economic Performance	L-M	L
F. Implementation Efficacy		
: Shift the System	L	L
: Linkages	M	L-M
: Community-Based	L-M	L

Legend: (H) High, (M) Medium, (L) Low, (–) Unable to say anything

3.3 CRITERIA AND THE MODELS

Section I : ORGANIZATION AND MANAGERIAL ASPECTS

I.a Community Participation Models

In this group of models, we have included Community Health Centres (CHCs), Local Community Services Centres (CLSCs in Quebec), Integrated Health Care Organizations (OSIS in Quebec), and Co-operative Health Centres (COOPS). Each of the models included in this category emphasize community involvement in some way. The *Community Health Centre* (CHC) is sponsored by representatives or groups located geographically within the community. The latter usually is a defined area that the centre is serving. The CHC is managed by an elected Board of Directors which generally includes client representation. One of the obvious strengths of the CHC is the role of the Board of Directors in community control and program design.

The *Local Community Services Centres* (CLSC) in Quebec are government sponsored, but are managed by a Board of Directors comprising two "Ministry" representatives and five elected local (community) people. Here, community is a restricted geographic area or district. A strength, which is more theoretical than actual, is the encouragement of community participation in the control and management of the CLSC. Another Quebec initiative, which still is in the early stages of implementation, is the *Integrated Health Care Organizations* (OSIS). Basically, OSIS are sponsored by an establishment, a group of establishments, private practices and polyclinics, and managed by a Board of Directors. Community involvement would be through people in the community who enrol on a voluntary basis. At this point in time, it is not known how much involvement community members would have on the Board of Directors. Participation of the community is to be "encouraged", which is significantly different than the committed involvement one might see in the CHCs, and as one definitely observes in the COOP model.

Sponsorship in the *Health Co-operative Model* (COOPs) is through co-operative membership, i.e., members are both the users of services and the determining agents of which services will be provided. Management occurs through the Board of Directors who are elected from the member users of the co-operative. While the CHCs involve the community on the Board, membership control and ownership are not nearly as extensive as with the COOP model.

With respect to *community participation*, the models within this group consider it a necessary element for determining community needs. The degree of such participation depends on the importance which the community places on such participation. Community participation can be facilitated through Board representation, committees of the Board, development of needs assessment, satisfaction surveys, fundraising, volunteer involvement, etc. The important point to remember is that not everyone in the community wants to participate in the development and implementation in the delivery of health care and social services. For those who do, the most viable models are the COOPs and the CHCs.

Because *funding arrangements* determine, to a large extent, the range of services provided and the focus of an alternative model of delivery, they are a key factor in the organizational and managerial considerations. Basically, there are three funding alternatives: fee-for-service, budget, and capitation.

Community Health Centres (CHCs) receive funding on a program, line-by-line basis. Generally, line-by-line budgets restrict flexibility, but many CHCs accept this positively for it establishes a consistent standard for funding. It appears that, over time, line-by-line budgets become more flexible in that funds can be juggled between different accounts. The CHC does not get penalized if "clients" seek services elsewhere. Some of the general weaknesses associated

with this type of funding are that budgets are based on previous year's costs, instead of current (or expected) expenses, that there are no incentives for managers to reduce operating costs, and that they are not eligible for the same tax benefits which have been available to hospitals. It should be noted, however, that budgets of CHCs in Ontario are not simply based on previous year's costs but do include factors related to current (or expected) expenses as well as estimates of new programs. Furthermore, since the Ontario CHC Program method of budgeting is a modified line-by-line approach, it has been suggested that incentives do exist for managers to reduce operating costs; these incentives perhaps are not as significant as in other funding arrangements. Indeed, it is possible that CHCs could be capitated instead of being budget funded.

Local Community Services Centres (CLSCs) are funded by government to serve a defined geographical area. No financial penalties are applied if clients obtain services outside their boundary. Budgets are program oriented and, hence, one weakness is the multitude of separate program budgets with which the CLSCs must contend. Because of the source of funding, in times of economic constraints, CLSCs have had a tendency to cut back on various social action activities.

In the *Integrated Health Care Organizations* (OSIS) funding is to be on the basis of adjusted per capita finances. The OSIS is to be financed through publicly prepaid premiums to provide services to a voluntarily enroled population for a specific period of time. It is envisaged that this way of funding will create incentives to provide preventive services and to use the lowest-cost procedures while still maintaining high quality. Once enroled, the consumer would "lose the privilege" of choice (to a doctor, hospital, etc.).

With the *Health Co-operative Model* (COOP) funding usually is done on the basis of budgets or capitation/negation. In addition to some of the positive aspects of such funding mechanism (noted above for the other models), the COOP seems to offer a significant degree of flexibility in the utilization of a variety of funding models.

A major difficulty encountered by all the community participation models, especially the COOP, is the lack of "start up" and capital funding. It has been pointed out, however, that in Ontario both start-up and capital funds are available to CHCs, but not to HSOs. Because of the paucity of sources for such funding, especially via the private sector, it is particularly essential to create some innovative approaches in this regard. This is discussed in the chapter dealing with the implication for reform.

I.b Quasi Community Participation Models

This group of models comprises *Health Services Organizations* (HSOs), Health Maintenance Organizations (HMOs), Comprehensive Health Organizations (CHOs), and Multi-Service Centres (Multis). Each of the models in this "quasi" category may or may not emphasize community involvement in the organization or management of the centres.

Depending on sponsorship, Health Services Organizations (HSOs) may be for-profit or not-for-profit. Most of the HSOs are physician-sponsored and, as a result, there is little community input or participation. The HSOs are managed by a "community" Board of Directors who are made up (primarily) of sponsoring physicians and/or medical faculty. Of all the HSOs in existence now, only two are operated by community boards, i.e., the Group Health Centre in Sault Ste. Marie and the Ste. Anne's Clinic in Ottawa. More as an exception than the rule, these older HSOs have a strong philosophical commitment to meeting community health needs and to providing a wide range of services in one location. Concern has been expressed that, in the future, one physician may be able to own and operate an HSO.

At present, *Health Maintenance Organizations* (HMOs) do not exist in Canada. Basically, an HMO is a grouping of physicians, other health personnel and facilities into a single system which provides a full range of medical services to a specific enroled population for a fixed fee in

advance. As a result, the HMO can exist as a "paper" organization (i.e., a set of contracts) or as a true organization. Sponsorship can be corporate (including co-operatives), physicians and/or government. Obviously, management and control depend on the ownership type, i.e., a group of physicians under contract with an HMO sponsor, a staff model where the HMO employs physicians, an Independent Practice Association (IPA), or a Network HMO which contracts with two or more IPAs.

Comprehensive Health Organizations (CHOs), which are not yet operational in Ontario, can be sponsored by the community, a hospital, a university, an HSO, a CHC, physicians, etc., and it is possible to have co-sponsorship. The CHO is to be managed and controlled by a Board of Directors who are elected/chosen from the members/enrollers/patients of the CHO. A potential weakness of the CHO is that community members are only "encouraged" to get involved in managing the organization.

Multi-Services Centres (Multis) can be sponsored by the government, community or private sectors. The Multis are managed and controlled by a Board of Directors whose members are appointed by the government to represent all political stripes and needs of the community, which is one of the perceived weaknesses of the Multis. The ownership and management of the Multis would reflect the types of services offered and the mandate of the centre. Multis can be community owned and involve voluntary input, thereby allowing the community to have a say in determining what services are provided.

Generally, these models are not active promoters of *community participation*. Much depends on the type of ownership and sponsorship created at the centres. Since most of the HSOs are physician sponsored, there is little community input or participation into determining what services are provided. Likewise, aside from a few "co-operative" models (e.g., Puget Sound in the U.S.), there is very little consumer representation or participation in HMOs. A potential weakness of the CHOs is the emphasis on "encouraged participation", rather than committed involvement of consumers. With respect to Multis, there may or may not be community participation or development activities.

Regarding *funding arrangements,* HSOs receive capitation payments to provide services to voluntarily rostered members and are financially accountable (i.e., "negated") for comparable services received outside the HSO. Since a negation only occurs when a rostered patient receives a service outside the HSO which is available at the HSO, negation has not been a significant problem for most HSOs. For small HSOs, disincentives in this regard may be the paper work required and the length of time before they receive notice of negation. For patients having available a comprehensive range of services *at one location* can be a strong incentive for members of HSOs. For physicians, there is the potential incentive to provide accessible and appropriate services while not compromising the patients' freedom to choose their providers for particular services. Another enticing feature of the HSOs is the ambulatory care incentive payment they receive if their members have fewer acute hospital days stay per 1,000 population than the age-sex standardization non-HSO population in their region.

For all HMOs, the organization which finances the HMO is also responsible for delivering services in an integrated system. This contractual responsibility ensures the delivery of a stated range of health services, including at least physician and hospital services. The organization responsible for financing and delivering services also bears responsibility for any financial risks/gains incurred in providing the services. One of the major strengths associated with the capitation payment mechanism of HMOs is that payments are made regardless of the service utilization pattern, thereby providing incentives to reduce hospital utilization and, hence, to control overall costs. Some of the weaknesses of HMOs are: the "community" tends to be employees and their families, thereby restricting catchment areas; capitation payments reflect the level of competition rather than projected costs of services and, thus, services are generally provided only if they are capable of generating surplus revenue.

For CHOs, funding is to be based on capitation which is derived from the total provincial cost of health care for a given population and ultimately refined for a specific region. This is not the same capitation formula used for HSOs. Significant strengths of this capitation funding are: any savings will be available for development of new and expanded community programs and other services beneficial to CHO members; enhanced quality assurance and evaluation of outcomes; and home based services. A potential weakness is the relatively large numbers of healthy enrollees required to make the CHO a viable concept.

In Multis, there may be public, private and non-profit sector funding. Being able to use this variety of funding sources is thought to be a strength of this particular model.

Except for HMOs, for which a significant strength is their access to capital, capital funding for HSOs, CHOs and Multis could represent notable challenges. Loans are not guaranteed and funds are not matched in any way. Some HSOs have had to undertake special capital fundraising campaigns. Private companies involved with HMOs, on the other hand, can issue stocks in the market to access needed dollars for capital expenditures.

I.c Minimal Community Participation Models

In the "minimal" group of alternatives are Hospital Affiliated Ambulatory Care Centres (HOSPs) and Physician Based Ambulatory Care Centres (PHYSs).

Neither of these models emphasize community involvement in the organization or management of the centres. *Hospital Affiliated Ambulatory Care Centres* (HOSPs), which are not-for-profit, are sponsored by the hospital and are managed/controlled by the hospital Board of Directors. The goal of HOSPs is to provide ambulatory care service either at or near a hospital, or through a free-standing, remote centre affiliated with a hospital. A strength of this model is that it allows hospitals to expand and grow by diversifying their role. Perceived weaknesses are the potential conflicts between goals of the HOSP and the hospital, and the lack of attention by hospitals to community representation or involvement.

Physician Based Ambulatory Care Centres (PHYSs) are for-profit polyclinics, sponsored by individual physicians and managed/controlled by physicians and/or private companies. Their aim is to provide medical services during convenient hours through "walk-in clinics or through off-hours telephone networks. About half the physicians in Canada operate in the PHYS model. A strength of this model is that the consumer/client can obtain medical treatment relatively quickly. Perceived weaknesses are the lack of community control of participation or of a formal mechanism for input as to what services are provided.

Between the HOSP and PHYS models, the HOSP (through its Board of Directors) comes closest to achieving some level of *community involvement*. The extent of this involvement depends on the type of hospital, the location (urban, small urban, rural), the mission of the hospital, hospital management, etc.

With respect to *funding arrangements,* HOSPs are funded out of the hospital's overall global budget, or by a separate operational budget for the centre which is allocated by the hospital. Depending on the circumstances, this situation can be viewed as a strength or a weakness. If the hospital Board is committed to the provision of HOSP services, then this likely is advantageous. Funding for PHYSs can be varied. A separate company may handle the business side. Physicians may charge on the fee-for-service basis, which could be paid on an hourly basis, or they could receive 50% of gross billings and offer equity in the clinics. A strength of this arrangement (from the physicians' perspective) is that doctors can control their income depending on the amount of services they provide. From the societal and government perspectives, this funding arrangement can lead to over-use of health care services and, hence, an inefficient use of services.

II.a Community Participation Models

Once the needs of the community in question are determined, the range of services to be provided can be decided upon. All of the models within the "community participation" category look at services from the broad definitional perspective of health, in that illness and wellness, and the physical, emotional and environmental determinants are considered. The type of services which can be provided are:

* health services (e.g., treatment, promotion/education, prevention, home, and even some in-patient services);
* diagnostic services (e.g., laboratory services);
* allied health services (e.g., physio/occupational therapy, dental services, pharmacy, dietary, and placement and coordination services);
* social services (e.g., information and referral services, mental health services, crisis and emergency services, support services, counselling services, legal counsel, etc.);
* community services (e.g., food banks, day care centres, recreational services).

In the *Community Health Centres* (CHCs) medical services are provided, complemented by preventive health, social and community development services. One of the strengths of the CHCs is the comprehensive range of health and social services delivered by multi-disciplinary teams. Yet, since restrictions prevent CHCs from advertising, it is difficult to raise awareness of these services to *potential* client members. CHCs often target their programs to people at high health risk, with high burdens of illness, and to people who have difficulty accessing the "system". A potential danger of such targeting is to isolate and fragment the groups who should be integrated more fully into society.

Local Community Services Centres (CLSCs) provide health services, walk-in clinics, primary social services, integrated services (with the focus on home care, mother and child, and schools), community organization, and prevention and integration of health, social service and social action. The key underlying rationale is to integrate CLSCs systematically with the rest of the health and social system. The emphasis is on ambulatory care. For the *Integrated Health Care Organization* (OSIS) the intention is to provide all health care and related social services guaranteed by the public system. An apparent or proposed strength of this model is that it will be able to offer a range of services that are not guaranteed under the present system, e.g., certain types of alternative therapy. There could be better coordination.

In the *Health Co-operative Model* (COOP) medical, preventive and social services are provided. The emphasis is on prevention, education and specialized programming in the provision of these direct health services. Again, like other community participation models, a strength is the provision of a comprehensive range of health services. In the delivery of medical services there is a significant emphasis on group practice. Finally the range of these health and social services is determined by the member-users, based primarily on needs. It is becoming more widely accepted that life circumstances cannot be segmented into health and social needs and, hence, both types of services should be offered together. Very importantly, for any of these models is the necessity of determining the community's needs before deciding upon which services to provide.

II.b Quasi Community Participation Models

Services offered by the *Health Services Organizations* (HSOs) include physician services (both primary and specialty) and health promotion/education and prevention. Most HSOs provide traditional health care services and do not concentrate on community development or on social services. They function well if there is not a pocket of specialized needs which have to be met. The "community sponsored" HSOs will offer more non-medical programs. One of their strengths is the capacity to provide continuous, integrated health care services. Since there is nothing to prevent enrollees from using out-of-plan services, negation has the potential to undermine the HSO's budget. The majority of HSOs are not providing integrated community-based services. The viability of HSOs is dependent on having enrollees with average health status; unless the capitation levels are adjusted appropriately, HSOs would not be appropriate for low-income communities.

One of the differentiating factors of *Health Maintenance Organizations* (HMOs) is their provision of hospital-based inpatient services, in addition to physician-based ambulatory care services. HMOs provide a comprehensive range of outpatient, inpatient, extended care, home care, mental health, drug benefits and optional (dental and vision) services. Except for emergency services, or when the enrollee is out of the area, members must obtain all services at the HMO. Yet, the HMO is not penalized; the client in this case simply pays for these other HMO services. A twenty-four hour telephone access to an HMO can facilitate access to services. Generally, services are not provided unless they have the capacity to generate income.

The *Comprehensive Health Organizations* (CHOs) are to provide as broad a range of vertically integrated medical and health care (primary, secondary and tertiary) services as possible. Depending on the community, social services may be included as well. Program designers think that one of the strengths of the CHOs is that they allow for the widest range of health services. Other potential strengths are the capacity to provide primary and specialty responses to illnesses or injuries and better coordination of health care services, ensuring continuity in health care services to their enrollees. A potential weakness for which to watch is that with co-ownership by organizations with different mandates, power struggles may develop.

Multi-Services Centres (Multis) provide a range of services, the extent of which depends on the needs of the community and the organization's mandate, i.e., social services, or health promotion/education, or emergency/diagnostic services, etc. As well, there may or may not be physicians' services. A strength of Multis is the flexibility in the services which can be provided. Since they can offer a variety of professionals situated in one location, a team approach to the provision of services and consequent continuous health care can be provided to members of the Multis. A real weakness exists if physicians' services are not provided.

II.c Minimal Community Participation Models

Services offered by the *Hospital Affiliated Ambulatory Care Centres* (HOSPs) include hospital-type non in-patient services (emergency services, public health nursing, home care coordination, etc.), but do not encompass primary physician services. One of the strengths of these arrangements is that affiliation with a hospital can lead to the provision of a fuller range of services, especially through links to the hospital for in-patient care. The HOSP also has access to key hospital resources, e.g., administrative mechanisms, personnel service, inservice education. A perceived weakness of HOSP services is the divergence between the types of services provided by the hospital HOSP and the types of services expected by the consumer. Also, HOSPs sometimes duplicate the services of Community Health Centres (CHCs)

Physician-Based Ambulatory Care Centres (PHYSs) provide medical services. An advantage of the clinics, with their location in high traffic areas (e.g., shopping malls), is that clients can obtain treatment conveniently and quickly. Weaknesses are that the walk-in clinics do not offer a broad enough range of services and are focused too narrowly, all of which prevent the continuity and integration of patient care.

Section III: ACCESSIBILITY

Accessibility means more than assuring physical accessibility, i.e., it encompasses flexible hours of operation, availability of a wide range of services, various referral systems, the location, transportation, language and cultural sensitivity, as well as physical accessibility. While we have eliminated direct economic barriers in accessing a variety of medical services, the indirect costs of access, e.g., transportation, sitters, time off work, etc., may still act as real barriers to access.

III.a Community Participation Models

All of the community participation models provide a variety of medical, preventive/promotive and social services. Having access to a wide range of services is an important incentive for seeking services at a particular centre. While physical accessibility is an important factor, it would seem that the availability and level of services are more important elements of accessibility.

For all the models considered here, budget constraints make it impossible to maintain services on a 24-hour basis, seven days a week. Many, however, try to maintain flexible hours of operation as well as holiday and week-end coverage, especially for "essential" services (which depend on the community profile) and during "peak" demand times.

As well as the formal patterns which exist among various agencies and institutions (through the providers), informal referrals (walk-ins, via friends, neighbours, telephone inquiry) are a major component of most of these models.

Depending on a variety of factors, e.g., resources available, needs, etc., these models address other components of accessibility (location, transportation, indirect economic barriers) in different ways. At the very minimum, physical accessibility and language and cultural sensitivity should be addressed by all community participation models. Curiously, while accessibility is accepted as an important aspect of health and social services delivery, and except for the "availability of a wide range of services", the literature and experience on these models do not deal explicitly with this component in a substantial way.

III.b Quasi Community Participation Models

Except for the US-based *Health Maintenance Organizations* (HMOs), where lack of health insurance prohibits access to services, *Health Services Organizations* (HSOs) and the *Multi-Services Organizations* (Multis) provide reasonable accessibility to whatever range of health and social services are determined as necessary by their respective Boards of Directors. It is expected that accessibility to *Comprehensive Health Organizations* (CHOs) services would be as good. It seems that the *Multi-Services Organizations* (Multis), which are located in urban areas, often serve satellite rural communities and, thus, would have the better potential to enhance accessibility, especially in terms of geographic accessibility. However, if no physicians' services are provided (which is the situation with many Multis), the accessibility has not been improved.

None of the models in this category appear to provide a comprehensive range of health, social and community services. HMOs would have the potential to provide a comprehensive range of physician ambulatory and inpatient/outpatient health care services. HSOs (and potentially CHOs) provide a broad level of health, prevention and promotion services. Multis have the most

potential to offer a wide range of health, related and social services. The important point to remember is that the *mandate* can determine what does (and does not) get provided. Because of the membership/roster/enrollee characteristics of these models, formal referral patterns among the various agencies and institutions are (or would be in the case of CHOs) well established.

III.c Minimal Community Participation Models

As was noted earlier, availability of services is a key component of accessibility. The greater the range of services available at one site, the greater the accessibility to health and social services. Also, location is an important factor.

In terms of the range of available services, the Hospital Affiliated Ambulatory Care Centres (HOSPs) would seem to have an advantage over the Physician Based Ambulatory Care Centres (PHYSs), yet, the HOSP still only provides access to hospital-type non in-patient services. The PHYS, on the other hand, provides access to primary physician services at locations and hours which are convenient to clients. Because of universal health insurance coverage, there are no direct economic barriers restricting access to either HOSP or PHYS services. Also, there are no geographic restrictions to either model. Both have good formal referral systems for medical and hospital services. Overall, however, neither model is this category appears capable of providing access to a wide range of health, health-related and social services.

Section IV: QUALITY OF CARE

Quality is certainly the "black box" in health care delivery. However, with an increasing amount of good evaluation research being done, we are beginning to learn more about the most appropriate medical and health care for patients.

IV.a Community Participation Models

Each of the models in this group delivers a comprehensive range of health services at a reasonably low cost. There is an incentive to use the least costly procedures. Hence, there is lower hospital utilization, fewer and less costly drug prescriptions, and lower overall costs of health services per client.

While the "evidence" is suggestive of quality improvements, we still would like to see reasonably reliable and valid evaluations undertaken to document these improvements. For instance, it would be good to know not only that utilization of hospital services are lower, and that costs overall are lower, but also that there are no real differences in health status between the groups who use these models and those who use the services of the "traditional" system.

IV.b Quasi Community Participation Models

The same comments which have been made with respect to the "community participation" alternatives are applicable to this group of health care models as well. As has been noted earlier in this study, there is tentative evidence which shows that the quality of care in *Health Services Organizations* (HSOs) and *Health Maintenance Organizations* (HMOs) is the same as that in the traditional fee-for-service sector. Indeed, there also appears to be less hospitalization of enrollees in these models. Yet, if the clients/members of these models are "healthier" to begin with, then the results may not be all that significant, all of which points to the necessity to undertake sound evaluation studies of the various alternatives.

IV.c Minimal Community Participation Models

As with the other models, the concept of quality of care is no easier to disentangle with these alternatives. With respect to the *Hospital Affiliated Ambulatory Care Centres* (HOSPs), some of their "strengths" are that they can improve bed utilization, (potentially) can improve the public's confidence in the hospital's ability to provide "quality" care, can enhance acceptance by the medical community (as a result of their "natural" affiliation with hospitals), and can provide research and teaching opportunities. All of these factors may interact to affect overall quality of care. On the other hand, since HOSPs do not emphasize prevention/promotion and non-hospital type alternatives, it is possible that HOSPs could adversely affect overall health status and quality of care. *Physician Based Ambulatory Care Centres* (PHYSs) likely provide high quality primary medical services, but because of their narrow focus, prevent the continuity and integration of quality patient care.

Section V: ECONOMIC PERFORMANCE

In assessing the economic performance of various alternatives, one could ask the following questions:

* has health status improved, using the same resources?
* has health status improved, using different resources?
* has health status been maintained using fewer resources?

A positive response to any of these questions would indicate improved cost effectiveness in the use of scarce health care resources.

V.a Community and Quasi Community Participation Models

Most of the evidence on the performance of alternative models comes from the U.S., particularly in relation to *Health Maintenance Organizations* (HMOs). Some Canadian studies on *Community Health Centres* (CHCs), *Health Services Organizations* (HSOs) and *Health Co-operatives* (COOPs) have been done as well.

We summarize here the principal findings of these studies:

* they have lower rates of hospitalization of their patients
* they are better structured to provide preventive services to their patients
* physicians in these models are more likely to believe their remuneration method is conducive to the delivery of preventive services
* lengths of stay in hospital are lower for their patients
* drug (and overall) costs per client are lower
* it also appears that some models provide higher quality of care

It would seem that this evidence is documented more clearly for the Health Co-operative Models (COOPs) and for the *Community Health Centres* (CHCs). Yet, it also appears likely that the *Local Community Services Centres* (CLSCs) and the *Integrated Health Care Organizations* (OSIS) in Quebec have the same potential. Indeed, the CLSCs have been found to provide higher quality of care for patients with headaches, more appropriate cancer screening, better cancer prevention services, and more complete childhood immunization.

V.b Minimal Community Participation Models

One of the primary criticisms of *Physician Based Ambulatory Care Centres* (PHYSs) and *Hospital Affiliated Ambulatory Care Centres* (HOSPs) is that, through the fee-for-service system of reimbursement, they can lead to over-use of health care services. Hence, these models lead to an inefficient use of scarce health care resources. Perhaps HOSPs could be used effectively to reduce the rate of hospitalization and to lower lengths of stay in hospital. Yet, it still remains that the open-ended fee-for-service system is causing policy makers to search for other delivery alternatives in order to improve efficiency in the provision of health care services.

For all the models considered in this study, it is important to note that there are factors in addition to the payment mechanisms which can affect the cost and quality of health care services, i.e.,

* practice organization (solo vs. group)
* peer review
* other financial incentives
* other organizational (e.g., institutional) links
* use of non-physician providers.

In order to say more (empirically) about the economic performance of the various alternatives, evaluations would have to be much better than they are at the present time. First, we would need primary objectives vis-à-vis the broad goal of improving efficiency in the provision of health care services, e.g.,

* shift physicians out of the fee-for-service system of practice
* reduce hospital use
* increase disease prevention and health promotion
* improve maintenance care for the chronically ill
* improve health status

Then measurable targets could be specified and evaluations of progress undertaken. There is no reason that federal, provincial, regional and local health objectives could not be established. The evaluation criteria would include quality of life measures as well as cost savings, and would encompass prevention/promotion services as well as the more traditional health care services.

Section VI: IMPLEMENTATION EFFICACY

Across the country, there has been increasing concern for rising health care costs (including issues related to funding/revenue, efficiency, effectiveness, utilization), dissatisfaction with the existing organizational structure of health care delivery, human resources requirements (especially nurses and physicians), technology, and quality and accessibility of care. "Fiscality", which represents the major underlying thread throughout, is linked to issues related to human resources, technology and *alternative approaches* to health care delivery.

How well do these alternative models perform (or would perform) in trying to implement various government objectives and policies? Before discussing this aspect in some detail, it is important to point out that "at the present time in Canada, no health co-operative has had the opportunity to fill the role that we envisage could be performed by such co-ops. For that to take place requires important changes in government policies and, indeed, when one considers the legal and financial obstacles and the institutional constraints, one is surprised to find that health co-operatives, *in some form or another*, exist at all" (National Task Force on Co-operative Development:83). Indeed, it could be said that, for all of the community and quasi community

participation models, the playing field has not been the same as that of the more traditional alternatives.

VI.a Community Participation Models

Given that all of these models are funded on a budget or capitation/negation basis, they have the potential to shift the system of remuneration away from fee-for-service and, hence, reduce the utilization of expensive medical and hospital services. Indeed, as was noted earlier, tentative evidence suggests that these results do occur. How effective are the incentives to enter into practice in such alternatives? The key incentives for physicians would be:

* competitive remuneration and benefits
* reduced administrative responsibilities
* lifestyle option
* practice in an innovative environment
* emphasis on promotion and prevention
* focus on using appropriate skills
* work collegially in a community setting.

Obvious disincentives are:

* lack of control of business and management decisions
* lack of fee-for-service funding.

The community participation models should be able to offer competitive salaries and attractive benefit packages, including such items as paid education and training leave, and paid vacations. Less tangible benefits (but growing in importance for younger male and female physicians) are freedom from office management responsibilities and lifestyle options such as good on-call schedules, a reasonable number of hours per week, job sharing, etc. The possibility exists for creating a management structure in these models which would provide physicians the opportunity to *participate* in decision making. Once the salary and benefits area is determined, then providers will be attracted if management of the centre is credible, if good staff are available, and if quality services are provided.

Lack of acceptance by one or more professional groups can undermine the implementation of alternative models and realization of key government objectives and priorities. It is important to remember that alternative models will not attain their goals (or realize their potential) at the expense of the people upon whom they are dependent to make the centres work, namely physicians and other professionals.

Thus, while these models have the potential to shift practice remuneration/reimbursement patterns, it still has not been fully realized.

In the area of *linkages and networks*, it appears that informal arrangements exist within communities for networking to occur between professionals and agencies. Since physicians have well-established formal links to various services and organizations, it is important to gain acceptance by the physician community. Few formal networks exist at the present time, and it is essential these formal linkages with other components of the health care system, the objective being to ensure a coordinated continuum of care.

As discussed earlier, these community participation models have the potential to reduce utilization of costly hospital services, drug costs, and overall costs per patient/client. Certainly, it also appears that these models have tremendous potential for success in *developing community-based alternatives* which emphasize disease prevention and health promotion/education. To

varying degrees, the inclusion of prevention, promotion and education is evident in most of these alternatives. Also to varying degrees, most of the community participation models have developed community involvement, either directly as in the case of the *Health Co-operatives* (COOPs), or through sponsoring groups and elected Boards of Directors as in the case of the *Community Health Centres* (CHCs) and *Local Community Services Centres* (CLSCs). Since the *Integrated Health Care Organizations* (OSIS) and Comprehensive Health Organizations (CHOs) are not yet operational, nothing substantive can be stated in this regard.

VI.b Quasi Community Participation Models

Three of the four models in this group (*Health Services Organizations* (HSOs), *Health Maintenance Organizations* (HMOs) and Comprehensive Health Organizations (CHOs) work on the capitation basis, while the *Multi-Services Centres* (Multis) can be a "hybrid" of different mechanisms to reimburse providers. Hence, all have the potential *to shift the system of remuneration* away from the fee-for-service practice. Reduced hospitalization and lower overall costs are the results. It also appears that many health care providers are given sufficient incentives to enter into the various capitation-type arrangements.

With respect to *linkages and networks,* models in this category appear to effectively make the connections among the wide array of health care services. Less successful are the links with related, social and community services, that is, except for perhaps the Multis. Since the physicians are the ones who have the means to establish the formal networks, and since they are key actors in the HSOs, HMOs and CHOs, the potential for realizing the vertical integration of primary, secondary and tertiary (both ambulatory and in-patient) health care services is good.

Regarding *community-based alternatives* for promotion and prevention services, these models may not be as "successful" (or as well-oriented) as are the community participation models. Basically, in HSOs the focus is on a range of medical services provided by physician/nurse teams with *some* preventive and health promotion services. Community-sponsored HSOs have more non-medical programs. The HMOs emphasize the "maintenance" aspect of providing medical services. For CHOs, it would appear that health promotion and prevention are not the major emphases (at least at the outset). Multis, depending on their mandate and the perceived needs of the community, health promotion/education or prevention may or may not be provided. Yet, the potential for doing so in Multis is significant.

VI.c Minimal Community Participation Models

Neither of the models in this category could easily be amenable for achieving some major policy objectives and priorities. In fact, it is precisely the *fee-for-service* system of the PHYS models which the policy makers are *attempting to shift,* and to reduce the use of expensive medical and hospital services. Many physicians are not willing to give up the fee-for-service reimbursement mechanism and, hence, would not likely easily accept other alternatives.

Based on the traditional referral patterns of physicians, the *linkages and networks* between *Hospital Affiliated Ambulatory Care Centres* (HOSPs) and *Physician Based Ambulatory Care Centres* (PHYSs) are relatively well formalized. However, linkages with other components of the health, related and social services sectors (either formally or informally) are not nearly as well established. It is unlikely that either the HOSP or PHYS models would easily facilitate these networks.

The development of *community-based alternatives* which involve community participation and the provision of a wide range of health, social and community services and which emphasize disease prevention and health promotion/education, are policy directions which would be difficult to be achieved by the HOSP and PHYS models.

CHAPTER 4: CO-OPERATIVE/CONSUMER SPONSORED HEALTH CARE AND GOVERNMENT HEALTH PRIORITIES

4.1 THE ADVANTAGES OF CO-OPERATIVE/CONSUMER SPONSORED HEALTH CENTRES

We present first the salient findings of the previous chapters, focusing largely on the performance and potential of the co-operative or consumer sponsored health care delivery models (community health centres). We documented significant economic, administrative, planning and organizational advantages of such centres. Later, we will argue that these advantages should make the co-operative/consumer sponsored health centres an excellent vehicle for carrying out and meeting the government's health priorities and objectives.

Community health centres offer substantial economic advantages. Their overall health care cost per patient is lower than a matched or comparable group of patients of fee-for-service practitioners. Much of this difference is due to their significantly lower hospital utilization rates. HSO and community health centre (CHC) physicians have higher patient loads, though physician cost per patient appear to be more or less the same between the different delivery modalities (Birch and Lomas, 1990). CHC's emphasis on multi-disciplinary teams make them better and more cost-effective users of health care professionals than either the HSOs or the fee-for-service medical practices. The quality of care appears to be similar across the different health care delivery modalities. CHCs are preferred to either the HSOs and obviously the fee-for-service sector in terms of the provision of prevention and health promotion services. CHCs have lower drug costs per patient than the fee-for-service sector, and are probably lower than the HSOs. They may well have a similar advantage in the delivery of outpatient, x-ray or laboratory services though the evidence is scanty in this instance. Patient satisfaction seems to be similar for the different health care modalities. In brief, community health centres are superior to the fee-for-service delivery modality on economic or cost-effectiveness basis and are at least as good as or better (for instance in use of non-physician health professionals and paraprofessionals, in the provision of preventive and health promotion services) than HSOs. It is sometimes argued that the above overall conclusions about the cost advantages of the centres are invalid because of methodological and statistical limitations. There is, first of all, little evidence and none that we know of that either the fee-for-service or HSO modalities are more cost-effective than CHCs. Secondly, the extant studies may have underestimated the cost-effectiveness of CHCs, that is, the bias may run the other way. It is well known that CHCs serve poorer socio-economic or otherwise disadvantaged groups, who have higher incidence of disease and disability and therefore have a greater need for health care services.

A needs-adjusted comparison of performance would make the CHC even better than it has been judged hitherto. An analysis that satisfactorily incorporates the differential levels and kinds of needs of the patients served by the different health care delivery modalities has not been undertaken.

There are, of course, other economic advantages offered by the CHCs. In contrast to the fee-for-service modality they offer better cost and expenditure control, more predictable budgets and the planning of programs. HSOs too, afford the government similar advantages. Additionally there are bureaucratic and political advantages. In contrast to the budgeting of CHCs, negotiations over fee schedule changes and related issues such as utilization controls and binding arbitration have been increasingly contentious and subject to acrimonious arguments. Threats of strikes have become more common recently. Indeed, some co-operative and community health centres were established during periods of doctor strikes (for example, the infamous doctor strike in Saskatchewan in the early nineteen sixties) and illustrate yet another of their organizational advantages. During strikes they are ready to serve the public, and the more there are of them the

less effective is the strike to the medical profession. Another major economic attribute is its insistence on non-fee-for-service methods of paying physicians. Provincial governments are increasingly aware of the relative virtues of capitation, salary and fee-for-service methods of reimbursing physicians. The latter creates a strong incentive to over service patients in the form of unnecessary referrals or revisits, unnecessary hospital admissions, higher lengths of inpatient stays, too many prescriptions, laboratory tests and the like. While capitation and salary system are alleged to have the opposite incentive, i.e. underservicing, there is little evidence of this. Several US studies that have examined this hypothesis reject it. In a system in which patients have free choice, easy mobility, and patient's rights, and in which doctors typically obey their code of ethics, underservicing is rather unlikely. It is much easier for patients to recognize underservicing and respond to it, as compared to being offered and given more than what may be necessary.

Among the other positive attributes of CHCs we documented earlier are their impressive record of innovations and improvements in making services more accessible to disadvantaged groups. We also noted that the success of CHCs in this latter regard has created an "image" problem, an issue we discuss later in this chapter. CHCs have also been successful in integrating health and social services and indeed some of their innovativeness is exhibited precisely in the integrated programs. We suggested that the innovations, integrations of health with non-health services, and improvements in accessibility are interrelated phenomena. It is this which gives the primary health care orientation of CHCs its truer meaning, and not one that is limited to basic health care services. CHCs are putting into practice what governments have come to acknowledge increasingly, that the determinants of population health include much more than the provision of health care services. An array of social, educational, economic, housing, nutrition, counselling, preventive and health promotion programs are also needed, to cite the more important ones. The recognition of this fundamentally different view of health, one that finds the medical paradigm inadequate, requires not only changes in public policy and the existing pattern of resource allocation but a new configuration of delivery systems. The integration of services is important to the success or otherwise of many of the government's priorities and objectives. The lack of effective integration of public programs is one reason why the deinstitutionalization and home care programs, for example, have, if not failed, fallen short of their potential. We also believe that the CHCs have been constrained by limited budgets from doing more in these areas; and thus they too have delivered less than their potential. The scope of their services has therefore been limited and, very importantly, targeted at very select and specific population groups.

The other reason for the disappointing results to date is the lack of planning, administrative and managerial weaknesses, and organizational difficulties. Government ministries are not yet organized to put into effect the more complex multi-service coordinated healthy public policies that they have come to espouse. The fee-for-service private practitioners and the HSOs are likewise not organized nor even willing to implement the new public policy strategies. By contrast, the CHCs throughout Canada have a better understanding of the new policy strategies and have exhibited a considerable interest in the requisite planning, administration and managerial challenges that these strategies present. In Ontario for example, HSOs are not involved in local planning and do not submit new programs for review to the District Health Council in their area. The new health policy strategy also calls for and requires decentralization and formative and summative evaluation of programs. The CHCs are, to put it simply, advocates of both.

Lastly, but very importantly, CHCs most probably permit a greater extent of consumer choice in decisions about health care services, and definitely permit and indeed most CHCs require public involvement in the setting of priorities, operational practice, program planning and administration of the facility. Public participation in HSO and fee-for-service is by contrast very limited (except in a few HSOs) or to put it bluntly, regarded as unprofessional.

We suggest that these positive outcomes and advantages, both economic and non-economic, are operationally and logically connected to the basic principles which define and govern the co-operative or consumer sponsored health care centre. These principles are:

1. community based organization and control
2. spectrum of primary health, social and related services in one location
3. multi-disciplinary teams to deliver medical services
4. emphasis on prevention, health promotion, education services, and ambulatory services
5. remuneration of health care professionals by salary or capitation rather than the fee-for-service method.

4.2 GOVERNMENT PRIORITIES AND OBJECTIVES

It is not difficult to make a list of government priorities or objectives. These can be learned from the spate of royal commissions and task forces on health we have had in Canada over the past four years. Virtually every province has had a major inquiry in the recent past. There are also speeches from the throne, government reports, policy announcements from Ministers of Health and official releases from advisory bodies on health policy. While a list of health care priorities or objectives is not difficult to establish it is quite another matter ranking them. Just how do we rank or weigh the many health care objectives the government appears to have? Are the weights and ranking the same between the provinces? The answer is not likely or not necessarily. These are not easy issues to resolve, and opinions or judgements between health policy analysts will differ on the matter of the importance governments attach to various health care objectives and priorities. Nevertheless, we think that many provinces would rank cost containment and health care expenditure control as their highest priority or objective. The fiscal deficit of the provinces, the fact that health care budgets constitute the largest single expenditure item in provincial budgets, the continuing trend of reductions in federal transfer (as a proportion of health care expenditures) and the still rapidly rising cost of health care services, makes cost and expenditure control the dominant priority of provincial governments.

A number of other objectives are related to or subsumed by the cost containment or expenditure control objective. It is useful to separate them because even though pursuing these objectives may contribute to the cost containment priority of the government, they are valid and important for other reasons as well. These include the shifting of some of the health care resources from treating illness in hospitals and physicians' offices to health promotion, prevention, and community-based services. A very important objective of government is to promote the appropriate use of health manpower, since health care services are labour-intensive and labour is the costliest component of most health care delivery systems. The reduction in the per capita demand and use of inpatient beds in hospitals and in the institutional sector generally is another high priority of governments. If longer term and permanent savings in expenditures in the health care sector are to be attained, the reduction in admission rates and lengths of stay, and most importantly, a similar decrease in the supply of beds per capita is, for all practical purposes, essential.

Provincial governments have not been very forthright or clear about the most desirable method of paying physicians, no doubt, to avoid open confrontation with the medical profession. It is true that they have encouraged and increased the proportion of physicians paid by salary or capitation methods. They have declared that such alternative methods have desirable features and have produced (sometimes very impressive) savings in health care costs. But they have not aggressively pursued the objective of transforming even large numbers of physicians from the fee-for-service methods of payment to capitation or salary methods. Quite often this objective is left implicit in government announcement of reforms. The term "incentives" for more "appropriate use of health care resources" by physicians, perhaps more directly, "appropriate levels

of services", is a softer and gentler way of saying that the fee-for-service method generates powerful economic incentives for the over-servicing of patients. The recent announcement by the Minister of Health of Ontario about a new delivery system called a Comprehensive Health Organization (Caplan, 1989) declares that "the organization will receive per-member payment from the Ministry...Physicians will be paid by the organization rather than by OHIP. They negotiate their compensation directly with their partner in the CHO" (Caplan, 1989, 5). There is no reference to physicians having to be paid by a salary or capitation method. The CHO is said to have the potential to contribute to the resolution of many of the fundamental issues we face in health care today. Eight such problems are cited but not one refers to the issue of how best to pay physicians (Caplan, 1989, 7-8). By contrast, a similar concept in Quebec called OSIS declares quite candidly that salary and capitation methods of paying are the preferred one in the new health care delivery model (Brunelle, 1988). We regard capitation and salary methods of paying physicians as a government priority and an important objective even though provincial bureaucrats and politicians have often lacked the courage to say so. Our judgement certainly has a solid basis in the theoretical and empirical analysis of the effects of the different methods of paying doctors (Evans, 1984).

All provincial governments have examined, in one way or another, their intention to develop "alternative models" of physician practice. This objective has inspired much planning and discussion in the recent years (for example, the CHO in Ontario and OSIS in Quebec). The "alternative models" is invariably thought of as the alternative to solo fee-for-service practice. Whether the alternative models of delivery must necessarily entail capitation or salary or some hybrid method of paying physicians is often left vague or unspecified. From the foregoing we would like to think so but it is irrelevant for our purposes here. We regard both the development of alternative models of health care delivery and alternative methods of paying physicians as legitimate and important objectives of health care reform. If the two are mutually reinforcing, all the better.

There is a related but separable health care objective of governments. The way governments fund or budget for health care services has become increasingly important over the recent few years. They have endeavoured to make health care costs and budgets more predictable. About half of the provinces have or are attempting to establish utilization controls or limits included as part of the fee schedule negotiation process. They have discovered that even relatively low percentage increases in fee schedules have led to unexpected high increases in the payments to fee-for-service physicians, the difference largely accounted for by changes in the mix and volume of services. Hospital budgets too have not been satisfactorily predictable as evidenced by frequent and sometimes high deficits. Consequently, predictability or control over expenditures has become an important issue to Ministries of Health, no doubt at the request or pressure from the Ministries of Finance.

Every province has, within the past decade, declared that the integration of disparate health services, and indeed the integration and co-ordination of health services with other public programs in the areas of social services, education, housing, job creation and income security is an important strategy for the present and foreseeable future. This objective has been given prominence and credibility by several ideas, most notably the primary health care concept promoted by the World Health Organization, the realization that despite the growth in the welfare state policies, people in need are still falling through the cracks and that lack of co-ordination has led to costly duplication of services and inefficient delivery systems. The problems are best exemplified by considering specific socio-economic population groups such as the elderly, native populations, and single mothers. The solution to these problems is epitomized by the concept of healthy public policies.

A relatively recent objective of government in the health care field is to encourage individuals to take greater responsibility for their own health. This is not at all related to patients assuming some greater financial responsibility through user fees or extra billing. Such ideas have been

quashed by the Canada Health Act, though there are some who feel that the user pay schemes will resurface in the future (Community Health Co-operative Federation of Saskatchewan, 1989). Individual responsibility has more to do with behaviourial changes in response to health promotion programs and related disease, illness and injury prevention. It has also much to do, we hope, with the greater individual decision-making in matters of choice about treatment and care. It also encompasses self-care and mutual aid initiatives and programs. Governments are now more conscious and sensitive about being criticized for "blaming the victim" so that they have progressed from the orientation and outlook implicit in the Lalonde document (1974).

Another relatively recent objective of government is to permit community participation in the planning and management of services. Many recent task forces and similar commissions of inquiry have recommended greater and more effective decentralization of the planning and management functions. Decentralization has proved to be an elusive and difficult objective to accomplish for governments throughout Canada. Governments' true attitudes about community involvement are difficult to gauge. Suffice to say that their record to date is less than impressive.

There is greater call for and emphasis on the evaluation of health policy, programs, and delivery systems. The concern about efficiency and cost-effectiveness is evident from the foregoing discussion. Many provincial governments have made improvements to their capacity to evaluate programs. Evaluation is almost everywhere a requirement for proposals on new programs, or the expansion of existing ones. The emphasis on evaluation is, of course, derivative of the need for governments to contain cost and to get better results from their existing commitments of health care resources.

A much repeated high priority objective of governments is to promote greater equity in the distribution of health care services (and indeed other services deriving from social policies) with the ultimate objective of reducing the inequalities in health status that still exist in Canada. There are cultural, class, geographic, linguistic and other barriers to access. Perhaps the more important reason for lack of access is the inappropriateness of the care that is available. The complexity of the delivery systems is another, and the spatially and uncoordinated nature of the health and other services a growing number of the aged, the young, select women's groups, etc. need is yet another barrier to access. While medicare services are accessible to all under uniform terms and conditions, the needs are hardly uniform and require quite different delivery systems. As we have said earlier, for many, better access comes only if services are integrated in a delivery system like the co-operative or consumer sponsored health centres.

4.3 COMMUNITY HEALTH CENTRES RECOMMENDED

It is apparent from the above discussion that co-operative or consumer sponsored health centres are an excellent vehicle for carrying out, in varying degrees, most if not all of the governments' objectives and priorities. Indeed, this is more true of community health centres than HSOs and most definitely, fee-for-service private practice. It is no wonder, therefore, that these centres were strongly recommended by virtually all the major studies and inquiries commissioned by provincial and federal governments since the late nineteen-sixties, not to speak of many more independent analyses of health delivery systems. Among the many earlier major reports that recommended such centres are the Task Force on the Cost of Health Service (1969), The Hastings Report (1972), Castonguay-Nepveu Report (1970), Anderson and Crichton Reports (1973) and the Foulkes Report (1973). Since then there have been numerous other reports reconfirming or restating the earlier recommendations. For the most part these recommendations went unchallenged by formal and substantive critiques. Unfortunately, they were also not implemented to anything close to extent that was hoped for or recommended except in Quebec. The expected growth in community health centres in Canada has not really occurred.

In Ontario for example, the Community Health Branch of the Ministry of Health administers the HSO, CHC and CHO Programs, but not the individual centres themselves. Home care or

placement coordination are no longer funded by this Branch. Of the total Ministry budget for fiscal year 1986-87, just under 3 percent was allocated to the Community Health Branch. It has been pointed out, however, that this allocation does not include payments to CHCs and HSOs from the Ministry's Health Insurance Division; hence, total funding of the CHCs and HSOs exceeds the direct 3 percent Branch allocation.

In 1987 there were 12 CHCs in Ontario; today there are 33 CHCs approved with several others being considered. The goal of "doubling to 6 percent by 1992" (Kagis and Muckle, 1987. 2) has already been surpassed and, with the expected announcement of new CHCs, this growth should continue. In 1989/90, the Ministry's operating funds for CHCs were $23.4 million, and it is projected that this allocation will increase by 42 percent to $33 million in 1990/91. A capital expenditure of some $10 million also has been projected. While these estimates seem small in comparison to funds allocated to the traditional components of the health care system, they are nonetheless very encouraging.

4.4 REASONS FOR LIMITED GROWTH

Among the more important reasons for the limited growth in community health centres are the following. Except in Quebec, and except for very brief periods in a few other provinces, governments have lacked the political will to actively promote co-operative or community health centres. It might be noted here that neither the government nor the medical profession see much, if any, difference between co-operative and community health centres.

Inadequate funding has been a major reason for the lack of growth of these centres as well as limiting the scope of their programming. Program budgeting and capital budgeting have been too tightly controlled by the government and non-government revenues are difficult to obtain, and in any case, limited as far as the financing of these centres is concerned.

The lack of political will permeated the bureaucracies of government. The lack of genuine and facilitative administrative support from public servants in the Ministries of Health during the formative years of the development of these centres also restricted their growth in number and size (Badgley, 1979).

There is a curious lack of legislative legitimacy which defines and regulates these centres. The lack of definition, goals and objectives has confused practitioners and administrators and led to complex bureaucratic procedures which made it difficult to establish new centres and expand existing ones. Indeed, it is politically easier to underfund facilities and programs which have no legally sanctioned roles or responsibilities. Government attempts to limit the growth in expenditure have tended to victimize the most defenceless, and the centres have little political power and small budgets. It also affects the use of health care professionals other than physicians. Thus "nurse practitioners have been permitted but not legitimized by legislation or recognized by funding" (Kagis and Muckle, 1978, 16).

Opposition to the centres by hospitals, but mainly and most vociferously by the medical profession is perhaps the most important reason for their limited growth. The lack of political will and bureaucratic support is often a reflection of the powerful pressure of the profession. The centres have been threatened with legal action for "advertising" and "unprofessional conduct" (Kettilson, 1985). Indeed, the HSOs too have come under severe criticism and suspicion by the medical profession (Linton and Peachey, 1987; Peachey, 1987; Ontario Medical Association, 1987). The CHC must appear to be a worse option to doctors given the differences between the CHCs and the HSOs, specifically community control, greater emphasis on team work and a greater difference in practice style. Capitation and the salary method of paying doctors are acceptable to the profession though they have a much greater preference for the fee-for-service method, and have always been willing to fight hard and exert professional peer pressure to preserve it as the pre-eminent method of paying physicians. Medical and hospital associations

wield an inordinate amount of power in the making of health policy, especially at the provincial government level. Hospitals too have regarded the CHCs as a threat to their autonomy and mission and a competitor for health care budgets (Hastings, 1986). The conflict and antipathy between the health centres and the profession is long and sometimes very bitter. Most governments have quite intentionally sought not to have any competition between the physicians and a community health centre. That is why the burden of proof through a needs assessment study is place squarely on the shoulders of community or consumer organizers. No such proof is required from a private fee-for-service practitioner before he or she applies for and receives a billing number.

Another factor explaining the slow growth of these centres is the difficulty in having and retaining medical personnel. The medical profession, through their associations, object to the "employed status" of doctors in CHCs. The centres which operate under budgets (not capitation) have unrealistic pay scales thrust on them, especially when it come to recruiting specialists (Griffith, 1987). High turnover rates disrupt team effort and continuity and reduces the morale of the centre. Patients too are dissatisfied with the uncertainties and the discontinuities such high turnover rates engender. Patients attachment to a specific physician is often underestimated to the detriment of the overall progress of an otherwise very valuable health delivery model.

Lack of member education is perhaps another factor why some centres have failed to grow. Patient and community involvement in many matters concerning the centre is vital, and a potent political "demonstration effect". After all, one of the more fundamental principles of CHCs is community control and involvement. There are complex socio-economic, and professional barriers to effective community control of health services (Brown, 1978; Metsch and Veney 1976; Klein, 1978). Conflicts between lay boards and the professionals is not at all uncommon (Lum, 1975; Kettilson, 1985). The public is generally unaware or not overly concerned about alternative delivery systems and that they can have a role or influence the nature and design of the care available to them. Marketing the concept of co-operative or community health centres is a necessary and vital activity. To date, this has not been adequately appreciated, so that its many advantages are not widely known to the public.

A related and critically important reason for the slow growth of the co-operative or consumer sponsored health centre is what we called its "image" problem. There is a strong and prevalent perception that the CHCs are established to serve mainly, if not only, particular disadvantaged groups in society. (This is not so for the HSOs). The view is understandable. As mentioned earlier the CHCs have been notably successful in meeting the needs of the disadvantaged. Integrated services too are thought to be needed by certain socio-economic or demographic groups. The emphasis on health and social services (that is the latter class of services) is not attractive to many who do not perceive themselves as "disadvantaged" or likely to become so. The location of CHCs in core city areas and near disadvantaged and poor precincts of high risk to health is hardly helpful in this respect. The inclusion of "priority groups" is part of the Ontario Ministry of Health definition of CHCs. This is not what the Hastings report recommended nor wanted (1972). Ironically but understandably given the tight budgets of CHCs, they were forced to focus even more on poor and disadvantaged groups. This dialectic reinforces the view of them being a "poor people's" service. They have not been considered as an alternative source of primary health care to the middle or upper income citizens. The CHCs have thus been "marginalized" themselves much like their client populations.

Another obstacle to the expansion and growth of CHCs is the view that they constitute an "add-on" and not a substitute for existing services. They may indeed be substitutes or complementary, but the "add-on" view persists. The confusion comes from the fact that CHCs do indeed make an attempt to meet unmet needs. This is more appropriately thought of as complementary programming which, in the nature of things, leads to cost-savings in the regular programs, through reductions in the use of them. Meeting unmet needs does lead to higher CHC budgets, of course. The issue of who and how much of the higher expenditures must be budgeted

for by Ministries of Health, social services and even other ministries is a complication inhibiting innovation and expansion.

4.5 SERVING GOVERNMENT PRIORITIES AND OBJECTIVES BETTER

Co-operative/consumer sponsored health centres can obviously serve and meet the government's priorities and objectives. They do so already, and could do so even better and more effectively with some modifications that either they or the government might bring about. We are of the view that much of the reform and change is the responsibility of the government but that the onus for pushing for the changes rests with the centres and the co-operative movement. Before proceeding we note that any reform of the health care system that fulfils to a greater or lesser degree the following criteria: (a) the government must be able to capture most of the cost-savings which result from the reform; (b) it must satisfy consumers; and, (c) it must satisfy the providers and organizers of care, will be readily implementable. Reforms that fail on one or more of the above will be correspondingly difficult to implement.

The Canadian Council on Social Development (1985) held a major conference on "Improving the Delivery of Community-Based Health and Social Services" in 1985. It recommended action and reform on several fronts but we refrain from listing them in full here. We highlight those that are specially relevant for the theme of this sections and offer others that we consider useful.

"A public policy commitment to developing community-based health and social services must therefore be accompanied by parallel commitments to organizational change and changes in funding priorities. To adopt the policy without assuring the means for its operation is to pass the responsibility while keeping the buck" (CCSD, 1985, 7). Increased financial support specific to the CHC is needed. This would take the form of startup grants; interest-free loans or loan guarantees or both; further capital support tied to planned reductions in hospital capacity; exemption from municipal and sales tax currently allowed to hospitals; federal and/or provincial seed money for organizational and marketing efforts; but most importantly, size of the operational funding of the CHC that is commensurate with their importance in the reform of the health care system. It should be stressed that this does not mean the government has to inject totally "new" or "additional" funds for the CHCs. Much of the funding can come from the "reallocation over time" of existing budgets, that is, by giving minimal increases to hospital budgets, rather large funds can be freed for the development of the CHCs. For the government to benefit from the expansion of CHCs, it must plan and act to reduce hospital and general institutional capacity in consonance with the decreased hospital utilizations. Failure to do so is squarely the responsibility of the government, and of course, not that of the CHCs. Thus far, it is the governments that have failed to capture the cost-savings that were made possible by the CHCs and the HSOs. A permanent and stable funding will also satisfy the clients or members of the CHCs and of course, the providers and organizers of the care of these CHCs. Provincial governments must cease year to year negotiation over funding and opt for a longer term budgeting process so as to allow better planning and management of resource by the CHCs.

Governments are now said to be interested in controlling costs above all else. In fact, some even claim that governments are not generally interested in quality of care and other objectives mentioned above. We disagree with the view that governments are only interested in cost containment, though we do believe it to be their most important objective at the present time. In Canada, cost containment is still largely of the "cut, freeze, and squeeze" variety. Thus, there are cutbacks in the Saskatchewan Dental Plan and the Prescription Drug Plan. Provinces (unsuccessfully) opposed the Canada Health Act which, in effect, forced them to abandon extra-billing and user fees. There was much talk about the virtues of privatization but that strategy too is of questionable value (Manga and Weller, 1982; Stoddard and Labelle, 1984). The cost-containment strategies to date have not proved to be very successful. Now it seems that the governments have no choice but to look at altering the health care delivery systems in order to achieve their cost-saving objectives. Whatever their political reservations about the CHCs option, the pressure

to contain costs should make the CHCs or similar such delivery mechanisms increasingly attractive to provincial governments. To be sure, saving on health care costs is not necessarily the most important, and certainly not the only, reason why the CHC model should be promoted. But, for any future growth of the CHCs in Canada to occur the cost containment objectives of the government must be satisfied. Such are the realities of resource allocation decisions in government currently.

The CHCs must take seriously their responsibility to be responsive to community needs and abide by the principle of community control, planning and management. It must force the government to similarly abide by the rhetoric that extols decentralization and community participation in decision making over health care services. The CHCs should avoid the game of grantmanship in order to raise funds for programs, and provinces must (and be asked to) show more flexibility in programming and not place physician-provided services as the main focus of program planning.

There have been numerous recommendations that provincial governments finally recognize community health centres as an important delivery model in the health care system. Legislation that sets out the CHC's role, its financing, organizational structures, accountability, and its operational principles and features is long overdue. For greater effectiveness, the CHC must be assured of basic rules, policies and procedures that defines its relationships with the government. Its financing, and all that flows from it, must not be left to whims of current politicians and bureaucrats.

The provincial governments should encourage competition between the fee-for-service physicians and the CHCs. Let the public decide which system they favour. This should encourage both the CHCs and the fee-for-service sectors to improve their quality of care and related elements of their servicing. Consumers are largely interested in issues of quality of care, types of services offered, continuity of care, of short waiting time to see a doctor, and of having access to a hospital bed when needed. They are less interested in issues of the relative efficiency of alternative delivery systems. Efforts to make them become more cost conscious are difficult and likely to be futile. Until recently, there was a deliberate effort on the part of the Ministries of Health to prevent the CHCs from competing with the fee-for-service physicians. We note and emphasize that the competition between the two does not give any incentive for the fee-for-service sector to provide less or less costly care. This is not necessarily true of the CHCs; their longer term survival and growth will depend on the extent to which they generate cost-savings. To sum up, CHCs must not only convince their clients that they offer a more appropriate range of services and offer as good or better quality of care than their competitors but they must also demonstrate to governments that they are more cost-effective at the same time.

The associations representing the co-operative/consumer-sponsored health centres should facilitate co-operative networks to increase the efficiency and improved management of the centres. The community health centres are not a homogenous group, and there are variations in their success in programming, effective use of resources and related matters. The idea of "satelliting" by which an established, experienced and successful community health centre helps establish, organize and manage a new centre for a while until it achieves the experience and establishes the routines and systems to become fully independent, is a useful one. Governments can be more assured of success with such satelliting, though it is not our intention at all to suggest that this is the only way to expand the number or size of the community health centres.

The associations could also play a useful role in assuring the government that co-operation between centres, and between centres and other delivery systems, should lead to reduction in the duplication of programs, of better planning in local areas and the sharing of scarce resources, both human and material. Networking can bring about efficiencies, for example, in the use of specialists, or capital resources such as laboratory, or equipment that requires greater volume of users for the efficient use (i.e. economies of scale). Improving the management information

system and establishing effective monitoring and statistical systems is yet another way the CHC associations can facilitate government efforts to enhance the efficiency of the various delivery systems. Indeed, as was pointed out in an earlier chapter, the CHCs have often requested a greater amount of the planning and evaluation of health programs. The demand for evaluative studies and the making of decisions for continued or changed funding on that basis is wise. Through program evaluation the CHCs are much more likely to be cost-effective in the delivery of their programs. It is an astute way to encourage the government to enhance evaluative studies of other (and not just CHC), health care delivery models. It goes without saying that while CHC-government co-operation in planning and evaluation must increase, both parties must avoid bureaucratization and must respect each other's roles and responsibilities. Government bureaucrats often fear the loss of control that comes from decentralization of decision-making, even when they have the ultimate control over budgets and the broader policies which govern the various health care delivery systems.

The CHCs could serve the government priorities and objectives better, and the government could serve the CHCs better, if both made a concerted attempt to alter the image of the CHCs from a "poor people's health centre" to one meant for everyone. There are mutual gains to be made by all, that is, it is in everyone's interest to fashion a new role and image for the CHCs. The provincial governments that now require the CHCs to specifically meet the needs of disadvantaged groups must drop this requirement. In other words, the CHC must not be regarded as merely filling in the gaps or niches in the health care system, even if the gaps are defined in terms of accessibility, higher disease burdens of specific populations and need for specialized services. A broader and general requirement should suffice. Nor should any geographical boundaries be imposed on the client catchment area of the CHCs. The style, mission and principles of the CHCs are such as to assume that they will endeavour to meet the needs of the underprivileged and the poor. The counterbalance to opening up the CHC membership to all on a voluntary basis is to insist on community involvement and control of the planning of programs, the operational principles of the CHC and its management. The image of the CHCs will also be improved by improvement in their facilities, their recognition and assured funding under legislation; marketing by both the CHC's themselves and the government itself; the implementation of quality assurance programs; the reduction in staff and physician turnover through better pay and working conditions; and giving the CHCs a higher profile in the bureaucracies of government and its agencies. To be sure, we are not counselling the CHCs to abandon their multi-service focus, their integration of services, or their traditional effort to serve the disadvantaged. These objectives are compatible with a more broad-based focus as far as the potential clientele of the CHCs are concerned. Some CHCs do in fact have such a broader and mixed clientele already, and simultaneously live up to the principles and practice ascribed to the CHCs in this report. In any case, the CHCs will have to respond to this image problem, as must governments.

Virtually everywhere in the western world the integration of health with other public services has proven to be difficult. The need for and the wisdom of the integration and co-ordination of services is also universally recognized. The difficulties and failures to date have been largely those of the government and mal-structured and mal-organized delivery systems. Government bureaucracies are not the most appropriately organized to begin with and inter-departmental planning and coordination is neither well developed nor easy to accomplish. It would be better if the delivery systems themselves planned and increased the integration of services in response to their community's needs and expressed desires. It is simply the case that not all groups need integrated services and those that are closest to delivering the services are better able (than government) to determine just what needs to be done. The associations of the CHCs can make a major contribution in the whole area of the integration and coordination of services and collaborate with the government in developing the appropriate policies, structure, programs and the like that are needed. This is simply not feasible for virtually any other health care delivery model. Indeed, the fee-for-service practitioners and most HSOs are neither competent nor even really interested in the issues discussed here.

The CHCs could also serve government priorities better with greater budgetary discipline, not that their record is bad in this respect. In fact, it is very good and the CHCs should be making much more of this in their dealings with the government. Both the fee-for-service medical practice and hospital sector have given government enormous difficulties as far as budget planning goes. The financial discipline of the CHCs can be further enhanced by improvement in management and administration of the CHCs. New or improved educational and training programs should prove to be a good investment of both the government and the CHCs.

We have said earlier that one of the greatest potential areas of efficiency gains and cost-savings is in health manpower substitution. The CHCs have performed better than any other delivery model in this respect. Yet the CHCs have not come close to exploiting the potential, no doubt because of professional-board conflict over further substitution, legal and legislative uncertainties and perhaps, most importantly, political pressure from the threatened professions. The CHCs could conduct further experimention in this whole area of more effective use of human resources. We would like to think, given the relative oversupply of physicians, that recruitment should not be as difficult as it once was. Changes in attitudes, education and training of new graduates should also help in making recruitment a little easier than before. Higher salary levels, improved fringe benefits and the like may be warranted and should be examined as an approach to attract and retain physicians. Whether doctors are paid on a salary or capitation basis is not as important as the fact that CHCs do not pay doctors on a fee-for-service basis. this obviously fulfils one of the objectives of government given their reservations and problems with that mode of payment. A roster of doctors interested in CHC employment is similar and useful and a simple idea to implement.

We have said enough of the innovativeness of CHCs earlier and do not need to repeat it here. We would like to mention one idea that deserves further thought and analysis. CHCs have been generally reluctant to offer extended walk-in or emergency services. These services are regarded as inconsistent with the holistic care philosophy of CHCs. However, there is a need and a demand for such services and there may be some advantages in offering them through CHCs rather than hospitals in the form of lower costs, improved accessibility, less queuing in emergency facilities at hospitals, and more importantly, the rationalization of hospital emergency facilities. Additionally, such encounters may provide the CHCs with an opportunity to educate clients about their health or risks to health, and it should also help with the recruitment of new members for the CHCs. The issues are by no means self-evident and should be assessed carefully before the idea is diffused in the health care system.

In summary, it should be apparent that there are a number of ways in which the co-operative or consumer-sponsored health centre can serve government priorities and objective better than they do at present. We wish to reiterate that in most cases what is required is government action and the formation of co-operative relationships between the government and the centres. Further, the legislative recognition of the centres as an integral component of the health care system is essential for bringing about the improvements we discussed above.

Are there limits to what the CHCs can offer or achieve? Yes, of course. Presently the limits are funding constraints, the hiring and retention of highly trained professionals and a concentration on particular needs of select socio-economic population groups. Any easing of these constraints will naturally allow the CHCs to do and achieve more as suggested above. But CHCs are not likely to alter the whole range of health and social services. Nor should they. Inpatient stays and much of the specialist care should normally be beyond the range of CHCs. An exception might be considered for community centres located in and serving a rural population or in remote areas where a small hospital may be considered to be inefficient but some inpatient stay capacity is nevertheless warranted. Such hospitals can be converted or redesigned and be made part of a co-operative or consumer sponsored health service. The CHCs should retain its focus on primary health care services. Some overlap with the public health units is inevitable but with planning and co-operation the overlap can be minimized, or even facilitated and accommodated. Many of the

ancillary and diagnostic services may be provided by units or facilities other than the CHCs themselves where economics and convenience warrants such separation. These limits are not problematic for the CHCs or the government. The CHCs may not be the sole provider of primary health care in Canada. Pluralism in delivery systems is not only unavoidable but should be welcomed.

We counsel the retention of a primary health care emphasis and orientation for the co-operative or community-sponsored health centres. However, in the rural areas of Canada, a vertical integration pattern which includes hospital services may not only be possible but also advisable. An explanation for this recommendation is warranted. CHCs are, in our opinion, the most useful and serve the government priorities and objectives best when they concentrate on primary services. It is most consistent with the principles and philosophy of care the CHCs operate under. The alternative is a variant of the HMO in the U.S.A. or the "northernized HMO" called comprehensive Health organizations currently actively considered in Ontario or the "Organisations de soins intégrés de santé" (OSIS) in Quebec. The US style HMO, Ontario's proposed CHO, and Quebec's proposed OSIS differ notably from the co-operative or community health centres we have focused on in this report. We discuss these differences briefly here. The most pertinent and most illustrative comparison is with the CHO model. It highlights the differences between the CHCs and CHOs, and the special features of the CHC model very well.

The CHO model has as yet not been implemented though serious consideration and planning has been devoted to the idea for the past two to three years in Ontario. The range of services of the CHO would be "broad" including physician, ambulatory, in-patient hospital and possibly some uninsured health services (as warranted). It would also provide or coordinate services such as nursing homes or home care. We note, however, that "broad" range of services focus primarily on health services and not necessarily (and not likely) on the integration of health with non-health services. Thus in our view the CHO is differentiable from the CHC in this very important respect.

Another significant difference is that while the CHO itself is to be funded by capitation, the physicians working in the CHO could be paid on a fee-for-service basis. The CHO model does not specify how doctors must be paid.

So far, the form and degree of community participation in the policy, program planning and direction of the CHO has not been made explicit. The CHCs are community controlled institutions, or at least, this is one of the basic principles of the co-operative philosophy. We doubt that the nature of community participation in the CHO delivery system will be like that for the CHCs.

These three differences are important for the co-operative movement in Canada. It is possible for a CHC or an HSO to expand into a CHO as presently conceived by the government of Ontario. But should a CHC do so? It is up to the individual CHC to decide the wisdom or otherwise of such a move. It is certainly not impossible to design and operate a CHO along the same principles and service philosophy as the current co-operative or community health centres. However, we believe that it would be fortuitous were this to be so. The Sault-Ste-Marie Health Service Association could be considered a CHO and does have to a respectable degree all the principles and features of a co-operative or community health centre. But its replication elsewhere is far from assured. Its history and experience makes it fairly unique, and only demonstrates what is possible but not necessarily likely. After all, it has been in operation for many years but so far there has not been another centre quite like it ever since in Ontario or elsewhere.

We suspect that CHOs in Ontario will have less community participation than is usually desired by the co-operative movement. There is also too great an emphasis on health care services and too little on other services. While capitation and salary payment methods may be preferred by the government, the CHOs can and will concede physicians fee-for-service methods of

payment. We suggest that these aspects of the CHO model are functionally related to its vertically integrated feature, that is, it involves both primary ambulatory care and specialized and institutional care. The more vertically integrated and complex the delivery system the more power could be vested in the medical professions and administrative-managerial personnel. Correspondingly there could be less effective community control. Similarly, for the issue of integrated services. The HMOs in the U.S.A. do not offer integrated services, if by "integration" we mean health and non-health services. The range of services are, by and large, medical services, and non-medical services refers to services in dentistry, physiotherapy, etc. that are closely related to or adjuncts to medical services.

We regard the multi-service centres such as the Cobequid Multi-Service Centre in Nova Scotia as very much like the community health centres we have discussed above. However, ambulatory care centres affiliated with a hospital are a different matter. They differ so much from the CHCs that we would regard them as not a good substitute model for the co-operative or community-sponsored health centre. They lack community representatives and participation and the services range is heavily focused on medical services, though they can and do offer health education and promotion programs. Even less acceptable as substitutes for the CHC model are the physician-based ambulatory care centres.

4.6 SELECTION CRITERIA

The foregoing discussion suggests that as far as government is concerned there are essentially three "competing" health care delivery models it needs to consider. As far as the co-operative movement is concerned there are basically two that may fulfil its principles and objectives. The government choice is between the CHC, HSO, and the CHO models (or close variants of these). For the co-operative movement the choice is narrowed down to one between the CHC or CHO model (or close variants of these). The selection of the preferred delivery model will depend on the weight the respective decision-makers attach to the criteria and principles which govern and define the different models. The physicians too have a preference between the different models. They quite naturally prefer the fee-for-service model, followed by the HSO or CHO and lastly (indeed, they do not favour) the CHC model. Their preference is determined largely by the method of payment and the degree of autonomy the different models offer.

The Ontario government's announcement of the CHO may have been inspired by the success of the HMOs in the U.S.A. and a popular view that an adaption of such a model would generate significant cost-savings in Canada. "American experiences suggest that vertical integration of ambulatory and hospital care is the most significant source of improved cost-effectiveness in alternative delivery modalities. Increased control over hospital utilization coupled with the financial incentive to reduce it consistently produces significant decreases in utilization" (Stoddart and Lomas, 1987, pp 3). The CHO is a vertically integrated delivery modality. However, both the HSOs and CHCs have reduced hospital utilization significantly without being vertically integrated. Vertical integration is not a necessary condition for reduced hospital use. Nor is vertical integration necessary for the incorporation of "financial incentives" to reduce hospital use. If desired, financial incentives can be built into the payment for or budgeting of HSOs and CHCs. Nor should it be assumed that were CHOs in Ontario to permit fee-for-service payment to physicians they would generate the same magnitude of savings as the HMOs do in the U.S.A.. As well, the public ownership of hospital in Canada in contrast to quite different ownership arrangements in the U.S.A. is a factor that might complicate and confound the transference of the U.S.A. experience with HMOs to Canada. To quote Stoddart and Lomas (1988, 3) "the order of magnitude of the improvement may not be generalizable due to differences between the two systems".

If hospital cost-savings were the only or the most significant criteria for choosing between the different models, there is no clear basis for preferring the CHCs or the HSOs over each other or the CHOs for that matter (noting, of course, that the latter organization does not as yet exist).

Yet other economic aspects would favour the CHC over the HSOs or the CHOs, specifically emphasis on prevention and health promotion, health education, and more importantly, better use of human resources. On other criteria such as innovativeness in the delivery of primary services, integration of services, community participation and the improvement of accessibility, the CHCs are clearly preferred over other models. It would seem that any weighting over these criteria would make the CHCs the preferred model.

Then why did provincial governments not increase the number or expand the existing CHCs? One explanation is that one of the criteria for the government's choice is the political pressure, *or what is the same thing, the acceptability* of a model to the medical profession and to a lesser extent, the hospital sector. It is perhaps this factor that weighs against the CHC model in the government's calculus over delivery modalities. When the Minister of Health of Ontario announced the CHO model to a conference of the Ontario Hospital Association (Caplan, 1989) she declared that "consensus is the real key to creating a CHO. Partnership among health care providers is the heart of the CHO concept" (Caplan, 1989, 5). One may ask, what about community involvement and participation? Equally troubling is the view that "doctors might be remunerated on the basis of the investment or their workload. They might receive a small bonus if the CHO achieves a budget surplus or they might devise a different approach" (Caplan, 1989, 5). Whatever "investment" and "workload" means is not at all certain, nor what might constitute a "small" bonus. And are doctors the only ones to receive a bonus? In any case, the statement is hardly a strong indication of the capitation or salary methods of physician remuneration. This appears to be an attempt to make a new delivery modality as acceptable to physicians as possible. If so, the CHC for all its proven merits and potential, remains marginalized by the health care policies in Canada.

CHAPTER 5: IMPLICATIONS FOR REFORM

5.1 INTRODUCTION

In all the recent provincial health care reviews, factors related to the organizational structures of health care delivery (including the search for alternatives), followed by cost concerns (containment, funding/revenues, efficiencies, effectiveness, utilization), and human resources were the key elements which precipitated the review processes. These provincial reviews recommended some major reforms and redirecting the system in three ways: towards greater emphasis on disease prevention and health promotion, towards community-based care alternatives, and towards greater accountability.

The theme of strategic redirection is clear. As well, there will be much more attention paid to improving planning guidelines and treatment protocols, in an effort to correct service maldistribution and inefficient utilization, aspects which overlap with improving management of and within the system. Rational planning, as opposed to institutional rivalry, efficient and appropriate use of hospital beds, and more controlled introduction of sophisticated technology and equipment are underlying goals of this organizational re-structuring.

5.2 ESSENTIAL CRITERIA FOR COMMUNITY HEALTH CARE

As has been noted elsewhere in this report, the health care system is in a state of transition and is attempting to meet a number of significant challenges. Among the health challenges are the rate of increasing chronic disease, an aging population, increasing proportions of people with disabilities, changing family and social structures, inequities in health status and access by disadvantaged groups, and the threats from the physical environment. Structural challenges facing the overall system are the separation and disconnection between preventive and curative health services and between institutional and community based services, the marginal status of community health services within the existing health care system, inadequate funding, high emphasis on specialized services, lack of jurisdictional and geographical coordination, insufficient accountability of health care services to local communities, and the need for increased involvement of community members in decision making.

If strong community health approaches are going to emerge which will address these challenges as well as be part of the theme of strategic redirection of the system, then several criteria will have to be taken into account (Lele, 1988).

5.2.1 Self-Reliance

The individual should be encouraged to be self-reliant. As a result, health care services should be directed towards supporting the individual's quest to maintain and enhance health for as long as possible. This includes the provision of necessary support services to assist people to remain at home. The principle of self-reliance also must recognize that, because of pressures on the individual's capacity to control various life events, people's capacity for healthy choices may be constrained, for which solutions may be at the collective as opposed to the individual level.

5.2.2 Quality of Life

In examining the cost-effectiveness of various alternatives, quality of life considerations should be factored into the examinations. Not only should costs be an important element in the push for de-institutionalization, but quality of life for the consumer/client should also be considered. Even when institutional care is a valid option, we should consider quality of life of the patient in our attempt to provide the most appropriate type and level of institutional care.

5.2.3 Informal Health Care

Informal health care makes a significant contribution to daily health practices and to continued independent functioning outside institutions. Because of the importance of informal caregivers, volunteers and mutual aid and self-help groups, community health services should support these informal networks.

Policy makers must realize that there is a "cost" of volunteering, e.g., sacrifice of scarce leisure time, volunteer "burn out", and that people must be not only be willing but able to participate as volunteers. In order to develop volunteerism in the community, there has to be an effective community development approach. Volunteers will not automatically be effective unless there is some mechanism in place to use them appropriately. The volunteer of one system might be the client of another, suggesting that communities should carefully assess the depth of their volunteer human resources so as to avoid serious blind-spots.

An equally important consideration is with respect to the various alternative care models themselves. Many are not equipping their staff with the knowledge and skills to be able to respond to people with special needs, e.g., elderly, persons with AIDS, disabled, etc. Adequate training programs are vital. It is essential to remember that in many cases it is the professional caregiver who is the anchor between formal and informal supports and, hence, they carry much greater responsibility (and pressure) than might be readily acknowledged. They need support, too.

5.2.4 Range of Services

In order to meet the range of needs and to accommodate the shifting between them, a range of health and social services are required. Non-medical support is a necessary element of the required care structure. Community health services are increasingly concerned with providing a continuum of care, from the initial recognition of the need for support of people living at home, through temporary hospital episodes, to placement in a facility when needed.

A key element in this continuum of care is mobility. The more effective we are at integrating and coordinating medical and non-medical services, the easier it will be for patients to move along them as required.

5.2.5 Physical and Social Environments

Not only should individual needs for improvements in health status and health care be addressed, but the collective physical and social environmental conditions must be dealt with as well. Economic conditions are related to many health problems and social assistance is critical to providing the socio-economically disadvantaged with sufficient financial resources to maintain adequate health standards and the elderly with the option of remaining in their own dwelling.

5.2.6 Comprehensive Approach

At the present time (as is apparent from the previous chapters) community support services are provided through a wide variety of service agencies, none of which have the mandate or the resources to undertake comprehensive functional assessments, to fuliy coordinate the delivery of a wide range of services, or to monitor changes in the individual's situation and to arrange modifications in the range, type or intensity of services provided as the person's needs change.

The need in community health is for a comprehensive community services system through which the range of services available can be provided systematically and consistently. This requirement for a comprehensive approach is at the root of increasing demand for intersectional, inter-agency and interdisciplinary co-operation and coordination.

Important questions of alternative allocations of funds between various services and technologies will only be seriously addressed when responsibility for allocating resources between services is shared collectively by representatives of those services locally and when they become publicly accountable.

5.3 COMMUNITY HEALTH STRATEGIES

5.3.1 Involving the Community

In one way or another, all of the community participation models involve members of the community in the organization and planning of community health services. Furthermore, community members are already involved in the provision of community health services in large numbers through such means as volunteer work and as informal caregivers. Yet, if informal health care is to be strengthened then existing alternatives will have to enhance their support for coordination and consultation as well as access to support services.

It is important to realize that not one model alone can "do it all". In addition to supporting the volunteers and informal caregivers, the contribution of mutual aid/self-help groups could also be enhanced by providing explicit support such as offering meeting places, assembling and disseminating information between them and about them, coordinating referrals and facilitating access to health professionals.

Community involvement is also critical in the planning of health services, especially regarding the need to include user perspectives in decisions which may affect them. As pressures on limited resources continue to increase, effective participation from the clients and community served is increasingly essential to the planning and provision of appropriate delivery of required services.

Not only should the informal networks be strengthened, but as well, the formal mechanisms must be in place to provide community input into the planning and decision-making process in order to make health care more responsive to changing needs and to improve its accessibility to all groups. While it is not absolutely critical to have community ownership of the alternative model, it is essential to have community representation on the Board of Directors. The Board must assure that effective needs assessments are conducted, that open meetings are held, that community development professionals be engaged, and that volunteer members are fully supported and trained. It is one thing to strive to have input from disadvantaged groups, but unless they receive basic support such as funds for sitters, transportation, and training sessions re: roles of Board members, then this type of representation will not occur.

5.3.2 Improving Accessibility

All of the models have improved efforts to meet the particular needs of underserviced groups. It is essential to try to address the basic issues related to inequalities of health and health services, such as poverty, unemployment and lack of marketable skills. Educational programs are not nearly sufficient to improve the health status of socio-economically disadvantaged groups. Instead, approaches which would raise *self-esteem* of individuals in these groups would be more effective.

Policy makers and community health workers will have to make locally appropriate choices and choose from among many community health alternatives. The appropriate service delivery methods will vary substantially according to the health needs of the community and the local social and political infrastructures.

5.3.3 Health Promotion and Disease Prevention

While we know that improvements in health status depend on changing lifestyles and on making responsible health choices, it is essential that all components of the health care sector

(including the institutional component) work together to encourage these changes. There is no doubt that policy makers can incorporate health promotion and disease prevention into health care delivery as fundamental principles. Yet that will not be sufficient. What is also required in order to achieve objectives of health, autonomy and high levels of quality of life are some fundamental changes in the basic attitudes of both users and providers of health care.

5.3.4 Coordinating Policies and Services

To coordinate policies and services at various levels, it is essential to establish effective mechanisms. While the need for intersectoral policy coordination has been acknowledged, it is very difficult to achieve when responsibilities are separated by jurisdictional and bureaucratic boundaries. As the impact of environmental and social problems on health becomes more apparent, the need for good intersectoral planning becomes more urgent.

The necessity for coordinating health and social services has been of primary urgency in the provision of care to socio-economically disadvantaged groups, but it also is becoming more urgent with the support services needs of growing numbers of elderly, especially if the goal is to help them maintain their independence. Coordination of institutional and community services is becoming more important as well. As the demand for services increases, so does the need for some rational system of allocation of resources. In Ontario, an important step in this direction already has been taken with the explicit integration of health and social services in programs for the elderly and disabled, as well as improving coordination between the Ministries of Health and of Community and Social Services.

5.3.5 From Individual to Community Health Care

During the past 10-15 years, a period when resources have been becoming more and more constrained and social problems have been increasing, we have witnessed great emphasis on the individual as responsible for his/her own health. We also have been learning that attempts directed towards individuals to redress problems whose causes lie in economic and social conditions have very limited success. Only people with adequate resources can meet their own needs.

When the problem is defined in terms of groups instead of individuals, solutions to the problem become much more evident. The wider the explanation of health problems, the greater is the actual possibility of attacking their roots. If we can effectively make these transitions from the individual to the group focus, the means of providing more effective service delivery would be better understood.

Although wide community participation in planning and coordinating services may be quite demanding for any one of the community participation health care models, the increased possibility of finding and implementing creative solutions to difficult problems can provide incentives and rewards for the effort involved. Yet, it is not always possible to build particular needs and interests of community members and groups into projects and programs within the existing frameworks of funding agencies. At such points, the frameworks (and perhaps even the different types of alternative models) will have to be challenged, rather than giving up the community's definition of its needs.

It is certain that the need for change has been identified by all participants in the health care system. The time and effort spent in bringing people together to clarify goals and objectives and to find practical ways of achieving them should be viewed as a legitimate health care activity. Perhaps, then, secure funding for such work may be found. It would seem that an important and necessary next step would be some constructive dialogue on the changes needed and how to implement them.

5.3.6 Cautionary Notes Regarding Community Participation

There is no question that community-based alternatives and community participation/involvement are worthwhile initiatives which have been gaining increased currency during the past few years. Yet, prior to embracing the community approach outright as a viable alternative/solution (or "the" panacea) to a number of health and related problems, we should be cognizant of a number of real and limiting factors.

Perhaps the first important consideration is the lack of real resources. Traditionally, government has been able to address various social policy problems through fiscal and other transfer payments. Yet, it is becoming more apparent than ever that, because of high deficit loads, decreasing revenue options, and reductions in transfer payments, governments are not equipped to respond to the increasing demand for a wide range of health, social and community services. The types of services required involve increasing amounts of personal time, primarily those from volunteers.

Another point to consider is that not only are the money resources scarce, but perhaps more importantly, the other resources (personal time, health and fitness, knowledge and technology, love and caring) with which to provide the critically needed community involvement are also scarce. Since these units of personal time are not inter-changeable in the same way as money resources, it is essential that communities know the depth and characteristics of human reserves with which to provide the needed input and support. For all community participation models, this is vital. A key challenge then is to determine the ability of a community to meet the relatively fast-growing wants for personal-time-dependent community health services with relatively slow-growing volumes of disposable personal time available to meet those wants. Even if it were more readily available, simply throwing money into these areas will do little to solve this problem.

An idiosyncrasy exists with respect to funding support. There is no doubt that better government and private sector support would be desirable, but there is a very delicate balance to try to maintain between this type of funding support and the autonomy and vigour associated with volunteer-supported efforts. The key goal here is to try to avoid formalizing and perhaps "bureaucratizing" services.

Another consideration is that the simple overlay of community participation model will not automatically achieve the desired results. If we think of disabled people in Canada, then the creation of independent living centres could be viewed as an analogy to trying to establish a community development model in health. Indeed, these excellent independent living centres are indicative of what can be accomplished if policy makers, researchers, disabled people, the elderly, etc., get together to find creative solutions in developing support systems which use both informal and formal networks. Yet, perhaps the essential ingredient in facilitating this success are the attitudinal changes which occurred. Instead of assuming that the people with whom we work as sick, helpless, need to be taken care of, and do not have anything to offer, it is more profitable to assume that people have skills and abilities and can participate in policy planning and organization, then a different type of paradigm from the traditional one can be created.

Attitude changes not only have to occur with the general public, but perhaps more importantly with the professionals. The latter have to do more "caring" and less "caring for".

Final points or cautions relate to just how far policy makers should go in "formalizing" support services provided by volunteers. Many employees in community delivery models carry a significant "volunteer" aspect in their jobs. If explicit policies are created, then policy makers run the risk of creating an unintended (but adverse) effect of employees cutting back on their volunteer efforts, resulting in the system having to identify a larger cadre of volunteers. Related to this aspect is that there really is a "cost" of volunteering: people must be not only willing but able to participate as volunteers. For example, in trying to get low-income individuals on the

Boards of community health centres, perhaps a large number of single parents might truly wish to volunteer, but if their situation is that they cannot afford a baby-sitter or transportation, they are unable to participate.

5.4 DIRECTIONS FOR THE FUTURE

Many of the models discussed in this report present ways in which aspects of better delivery of health care services might be accomplished. Not one of them, individually, represents the single, best approach. Depending on community needs and the local social and political infrastructures it would appear that any one of the four community participation models and perhaps even the Comprehensive Health Organization (CHO) could go a long way toward developing effective community-based delivery of integrated and continuous health care services. Not every model would work in every community. The choice for each community will vary, and arriving at "the" decision, trade-offs will have to be made in terms of the most important criteria which, in this case, likely are community participation, range of services offered, organization and management, and funding. The "best" model, in the end, is the one which reflects the particular nature of the community to be served.

All of the community participation alternatives demonstrate important key characteristics:

* they know what they are about and, hence, it is relatively easy for providers to identify with their mission, goals and objectives;
* they have incentives (both financial and professional) which encourage the best use of resources;
* their organizations are decentralized to the extent that team approaches are emphasized and that accountability and responsibility at every level facilitate strong decision making;
* since patients receive only the services which will provide benefits to them, the possibility of ensuring effective and efficient high quality services exists.

Given the discussion throughout this report, what then are some possible directions for the further development of co-operative/consumer sponsored alternative delivery models? As Rice suggested in a paper on health co-operatives, co-operative health centres should be viewed "as delivering group health services under a community board model with a preference for budget or capitation/negation funding. The important aspect is to allow for community involvement in health care whether it be a co-operative, non-profit corporation or association" (Rice, 3).

5.4.1 Organizational and Legislative Aspects

In an ideal world it would be desirable to have an agreed-upon set of national health objectives and standards from which various national associations and provincial governments and organizations could translate into action in one way or another. In the real world, however, this likely will not happen in the foreseeable future. In fact, as a result of the numerous provincial health care reviews, one can expect more provinces (individually) setting objectives and agenda for health care delivery, which makes it difficult for national groups to establish national goals and directions.

It would seem very difficult for one national organization such as the Canadian Co-operative Association and their counterpart the Conseil canadien de la coopération to make much headway on its own. However, since the Health Co-operatives (COOPs) share many of the characteristics of other community participation models, e.g., CHCs, CLSCs, OSIS and even some HSOs, a potential strategy for affecting change in the development of community-based alternatives may be to form specific alliances with the provincial and national associations which represent these models. Instead of trying to implement a common model across the country, it would be more advisable to foster a common approach, i.e., that of the community participation group as a whole.

This strategy would seem to make sense on a number of grounds. First, to varying degrees all of these community participation models rely on the Board of Directors mechanism to incorporate community involvement. The latter varies from province to province and from community to community, depending on the needs of the community and on the social and political characteristics of the community. One model may work well in one area but be totally unworkable elsewhere. In a country as broad as Canada, and even within our provinces, there is such diversity that no single system can serve all regions equally (Barkin:1987:8). Hence, a common, community participation approach which allows communities the choice could work very well.

Second, as was suggested earlier, the federal government is not in the frame of mind to establish new national standards. As long as the legislation in the Canada Health Act with respect to necessary hospital and medical services is respected, there will be no major difficulties with incorporating other services and programs which reflect the various community profiles. The only major challenge which alternative models would have to contend is that increasing access to services usually translates into increasing costs. Yet, if real integration and coordination of services in the community are pursued by the community participation models, there should be a reduction in "duplicated services" and, hence, an overall reduction in costs.

Third, there does not appear to be one, best ownership and management style. However, it is recognized that strong, professional management is imperative to the success of any ownership structure. These community participation models have strong potential to establish partnerships among providers, management, the Board (and the community) with clear objectives and roles laid out for each participant. Involvement of all parties could mean having providers on Boards making decisions about the allocation of resources to their respective fields, a situation which could raise the spectre of "conflict of interest". However, as long as the goals, objectives and priorities are clear and accepted this potential problem can be minimized.

A fourth reason for trying to establish a strong network of community participation organizations would be to assist the individual centres learn how to handle democratization inherent in these models. Community ownership strengthens communities and decentralizes ownership to the lowest political level. A potential downside of all of this democracy is the political interference which could be experienced by the individual centres as they attempt to conduct business. Many of these organizations would need help in trying to offset the powerful influence of central or more powerful bodies.

Hence, it could be recommended that national organizations such as the Canadian Co-operative Association and the Conseil canadien de la coopération assume the leadership roles in trying to expand the development of a community participation approach (as opposed to model) to health care delivery in Canada. This, then would encompass CHCs, CLSCs, OSIS, CHOs and COOPs.

5.4.2 Policy and Financial Aspects

It must be remembered that it is the provinces which pay for hospital and medical services. Under the E.P.F. arrangements between the federal and provincial governments, funds are transferred and the provinces have a great deal of flexibility in determining how and where those funds will be spent. Depending on the province's fiscal capacity and whether or not it is innovative/creative, the shape of health care delivery can vary quite noticeably from province to province. Some provinces have been much more "experimentive" than others, e.g., Quebec, Ontario (only recently), Manitoba and Saskatchewan. Hence, depending upon the government's vision (and will) initiatives such as CHCs, CLSCs, OSIS, and CHOs either are funded and tried or they are not. All of these initiatives suggest that it is not absolutely necessary to develop a new funding model, but to be flexible with what already exists. Of all of the funding model options, however, it appears that the capitation/negation system offers the most flexibility. Features in addition to the basic capitation/negation component which would complement the overall

funding aspects would be adjustment for above-average percentages of special needs patients, e.g., elderly, ambulatory care incentives, and supplemental core funding if locating in an area of special needs.

As there were reasons for suggesting a community participation approach, there also are factors behind suggesting flexibility in funding other than the fee-for-service system. There are problems associated with all the funding arrangements; however, the various models do appear to be functioning reasonably well under the various non-fee-for-service mechanisms. Budgets and capitation have their strengths and weaknesses, but depending (again) on the needs of the community and the social, political and management characteristics in these communities one funding mechanism may be preferred over another.

The major difficulty faced by all community participation models is the great difficulty in obtaining capital and "start up" funding. This is an essential reason for government funding of the community participation model, especially at the outset.

Without such "up front" funding, innovative approaches have to be found, as in the case of the Health Co-operative (COOPs). In this regard, the Conseil canadien de la coopération made a series of recommendations in October 1989:

1. that co-operatives encourage members to invest more in capitalization by one or several of the following ways: increase the number of qualifying shares, require members to contribute annually to the capital stock, determine the capital required of members according to their transactions carried on with the co-operative;

2. that co-operatives improve the permanence of their equity by collecting a substantial entry fee and paying part of the dividends in the form of shares;

3. that co-operatives improve the return on preferred shares, namely by indexing them at an external rate of interest or at their own surplus earning to equity ratio;

4. that co-operatives periodically re-evaluate their shares, so as to maintain the constant purchasing power of those shares;

5. that a federal tax incentive program for investment be established in co-operatives;

6. that it be made easier to invest shares in co-operatives in RRSPs;

7. that co-operatives be able to create a new capital item called a "shared reserve", which would be made up of re-invested surplus earnings that could perhaps be distributed to members;

8. that co-operatives examine the possibility of creating their own "security fund" which could be intended to secure loans, thus facilitating access to this type of funding; and

9. that co-operatives study the possibility of creating a body to finance them.

One can immediately envisage major difficulties here. First, the willingness and ability of members to increase their contributions might be restricted, especially if a large portion of members were in the low-middle income groups. Also, given the state of the federal budgetary/deficit position, it is very unlikely that any tax incentive would be established, or that RRSPs would be broadened in scope. Even if these recommendations were relatively viable, there still is the requirement for solid government support.

Hence, in collaboration with the other partners in the community participation models, it could be recommended that funding commitments for capitalization be sought from governments and that capitation/negation or budget funding be put forth as viable forms of operationally financing consumer participation health care delivery models. The larger the group of people and organizations advocating these positions, the greater may be the potential in moving government towards these actions.

5.4.3 Specific Directions to Consider

In addition to two broad recommendations above, the following might also be considered:

* Until only very recently only the alternative models of health care delivery have been required to prove their efficacy. However, since it takes time and some start-up costs to organize a different health care delivery alternative as well as to begin to see results, **the provincial governments should decide to shift existing health care resources for these start up costs involved in organizing community participation health models. For example, allocating even 1% of the increase in total hospital budgets may be sufficient.**
* **Provincial, federal and municipal tax policy for not-for-profit health centres should be brought into line with tax policy for hospitals.**
* If capitation funding is to be effective, then governments will have to "restrict' the choice of the patients/clients after they have made their initial choice of alternative or provider, i.e., "lock-in" regulations. Capitation-based health models cannot effectively plan and budget if it is to be penalized for out-of-service plan use by its enrollees. The "restriction" would have to include some attractive incentives to offset this reduction in freedom of choice. One could envisage these incentives involving comprehensive and coordinated care services including a range of supporting professional services available in one location. It is possible that as a result of improved operational efficiency, savings realized could be used to offer other services required by the members.
* A controversial element of "persuading" potential clients to enrol in a particular model, is whether or not to allow marketing. **If guidelines/standards were established for such marketing, then alternative models could promote their range of services, accessibility, etc., which would help clients make "informed" decisions about enroling for a fixed period of time with an alternative delivery model. As highlighted in the previous chapter, community participation models have an "image" problem. Effective marketing could be used to improve this situation at the same time.**
* Promoting the wider use of multidisciplinary teams in alternative models of health care delivery is seriously undermined by professional regulations and statistics. **In order to help achieve the efficient allocation and management of health care personnel, the existing legislative barriers will have to be removed or changed.**

CONCLUSIONS

There does not appear to be much doubt that the system will change; in fact, careful examination suggests that we are already in the midst of what could turn out to be some rather fundamental shifting of the health care system. Any alternative health care delivery models which stress community participation, health promotion and disease prevention, and different reimbursement mechanisms will form an integral part of that change.

It also seems clear that a community-based Board of Directors model which provides a wide range of health (as opposed to health care) services within a budget or capitation/negation funding mechanism is a feasible direction in which to go. It also appears that, depending on the needs of the community and its social and political characteristics, any one of the community participation models (Community Health Centres, Local Community Services Centres, Integrated Health Care Organizations, Co-operative Health Centres) or the Comprehensive Health Organizations would meet this overall goal and direction.

Hence, it would seem fruitful to foster and enhance the community participation approach in health and health care. This would mean coordinating the efforts of key models in this area (CHCs, CLSCs, OSIS, CHOs and COOPs) and clearly identifying their characteristics such that *communities* would be able to choose the model which best suits their circumstances. The funding mechanism, i.e., budget or capitation, also should be a matter of choice for the community.

Since capital funding is a problem for all of the community participation models, approaching government as a coordinated group of community participation models may have more "impact" on policy makers. Since each of these models have the potential to successfully implement emerging government objectives and priorities, i.e., restructuring, community-based, health promotion and disease prevention, and different funding mechanisms, it would appear that government would be receptive to the idea of providing necessary "start up" funding.

Again, however, communities would have to establish and document needs for services and would also have to demonstrate a good understanding of the social and political characteristics of their localities. Proposals for such community participation health models would have to resemble good business plans. This is where a national group which has interests in further community participation approach may play a very useful role: in the preparation of or establishing guidelines for the preparation of proposals to develop and implement such models.

Overall, then, Canada's provinces appear to be re-orienting the universal comprehensive public hospital and medical system towards greater efficiency of resource use. It is certain, however, that without governmental action and support, alternative delivery systems cannot compete fairly with the traditional system. The form that alternative delivery takes should depend on the needs of the community (which includes the traditional provider groups) it serves. It has to be recognized that, whatever the mechanism, a pivotal group is the physician. We are at a point in time where all of the community participation models have an opportunity to play a significant role in the implementation of alternative delivery mechanisms. The Canadian Co-operative Association and the Conseil canadien de la coopération (with the appropriate adjustments in the legislation to accommodate such changes) could take a key leadership function in this regard.

APPENDIX A

List of Key Informants
and
Interview Guide

Key Informants

Ms. Alexa Brewer
Policy Analyst
Health Policy Division
PCI Branch
Health and Welfare Canada

Dr. John E. F. Hastings
Associate Dean
Faculty of Medicine
University of Toronto

Ms. Charlotte Rosenbaum
Executive Director
North Kingston Community Health Centre
Kingston, Ontario

Ms. Denise Albrecht
Sandy Hill Health Centre
Ottawa, Ontario

Ms. Patti Sullivan
Executive Director
Klinic Community Health Centre
Winnipeg, Manitoba

Other informants on the study were interviewed for an earlier study on the same theme. The list is adapted from Angus, Tregunna and Dunne, 1989.

Community Health Centres

Wayne Edgar
Executive Director
Centretown Community Resource Centre
Ottawa, Ontario

Dr. Donna Bower
Primary Health Care Manager
Dalhousie Health and Community Centre
Ottawa, Ontario

Bonnie Dinning
Health Care Program Coordinator
Pinecrest-Queensway Community Service Centre
Ottawa, Ontario

Denise Albrecht
Executive Director
Sandy Hill Health Centre
Ottawa, Ontario

David Hole and Lynda Jones
Executive Director / Nursing Coordinator
South East Ottawa Community Health Centre
Ottawa, Ontario

Health Service Organizations

Dr. John Forster
Medical Director
Family Medical Centre

Madame Réjeanne Cuerrier
Executive Director
St. Anne's Clinic
Ottawa, Ontario

Fred Griffith
Executive Director
Sault Ste Marie and District Group Health Association
Sault Ste. Marie, Ontario

Other Ambulatory Care Centres

Geraldine Hutton
Executive Director
CLSC de l'Outaouais

Kevin McNamara
Executive Director
Cobequid Multi-service Centre
Lower Sackville, Nova Scotia

Roy Whetmore
Past Member & Chairman of the Community Board which developed Cobequid Multi-service Centre
Lower Sackville, Nova Scotia

Michael Sorochan, Director
Continuing Care Division
Vancouver Health Department
Vancouver, British Columbia

Brian Sullivan
Community Member, Planning Committee and Board of Directors
Guelph Community Health Centre
University of Guelph – Associate Vice President Student Affairs
Guelph, Ontario

Tom Marwick
Executive Director
Regina Community Clinic
Regina, Saskatchewan

Marie Lynch
Assistant Director, Professional Services and Planning
St. Joseph's Ambulatory Care Centre (not yet operational)

Government Representatives

Giah Eisenstein
Executive Director
Community Health Division
Ontario Ministry of Health
Toronto, Ontario

Mary Catharine Lindberg
Assistant Deputy Minister
Planning and Programs
Ontario Ministry of Health
Toronto, Ontario

Individuals

Eva James
site visit to Cobequid
Chairman, Kanata Health Care Committee
Member, WUHRSC Advisory Committee
Kanata, Ontario

Dr. Maureen Law
Interest and involvement in developing
union sponsored health centres
Ottawa, Ontario

Dr. James Lee
interest in HMOs
Consultant
Arthur D. Little Inc.
U.S.A.

Jonathan Lomas
Associate Coordinator
Health Economics and Policy Group
Department of Clinical Epidemiology and Biostatistics
Faculty of Health Sciences
McMaster University
Hamilton, Ontario

Dr. Janet Mitchell
interest in HMOs, research in area of physician group practices
President
Centre for Health Economics Research
U.S.A.

Thomas Regan
Chief of Research
Nova Scotia Royal Commission on
Health Services
Halifax, Nova Scotia

Dr. Duncan Robertson
involved with Geriatric Outreach Programs
interested in home-based and community care

Dr. Ralph Sutherland
interest in community development models
Professor
University of Ottawa
Ottawa, Ontario

Other informants who undertook special reviews and short interviews for the study include:

Yuping Hong
Misericordia Hospital
Winnipeg, Manitoba

Wendy Muckle
Sandy Hill Health Centre
Ottawa, Ontario

KEY INFORMANT INTERVIEW GUIDE
CO-OPERATIVE/CONSUMER SPONSORED HEALTH CARE SERVICES

Date:
Interviewer:
Key Informant:
Organization:
Position:
Address:
Telephone:

GENERAL:

* What type of co-operative/consumer sponsored health care model are you familiar with?
* What are the key services offered through this model? (or models you are familiar with)?

OWNERSHIP:

* What is the ownership structure of this Co-op model's board?
* What are the positive features of this ownership structure?
* Constraints associated with this type of ownership? Which ownership style do you most favour?

COMMUNITY PARTICIPATION:

* Is community participation encouraged in this model?
* At what level does it occur?
* In your view, has community participation worked?
* What facilitated community participation?
* What were the barriers/difficulties in implementing?
* How and by whom is a client referred to your service?
* What formal relationships have been established with institutions, agencies and professionals in the community?
* What informal relationships are established with facilities and professionals in the community?
* How well has this Co-op model worked in promoting current government health policy objectives, i.e., in terms of such things as integration/continuum of health care services, community-based services, promotion/prevention?

ACCESSIBILITY:

* How is accessibility assured at this Co-op model?
* How could accessibility be further improved?

FUNDING ARRANGEMENTS:

* How is this Co-op model funded?
* Are all programs funded in the same way? (ie. are there seconded staff, user fees, etc.)
* Does this funding mechanism enhance or impede service delivery in your opinion?
* Are you tied to a specific geographical catchment area?
* Are you penalized if enroled clients seek service elsewhere? even if they seek services not offered at this Co-op model.
* How do you deal with clients attending other services? (ie. encouraging them to remain)
* Can you serve clients outside the catchment area? Are you penalized for providing this type of service?

EFFICIENCY AND EFFECTIVENESS:

* What factors led to this style of care delivery?
* Were other care alternatives considered at the outset?
* What client needs are being met, and what are the advantages of this model in meeting them?
* How were these needs determined?
* What are the objectives of this Co-op model (measurable and attainable)?
* Are specific populations/needs targeted? On what basis?
* Does this Co-op model have criteria which must be met before a new service is added?
* Does it share resources with any other groups on a regional basis?
* Have their services and/or delivery been evaluated?
* Positive findings?
* Areas requiring further work?
* How does quality of services provided by these models compare with that of services provided elsewhere in the system?
* How is that "quality" measured?
* How do Co-op models interact with existing services?
* Are you aware of studies which have examined reductions in institutional use or other health/social service use due to availability of Co-op/consumer sponsored health care services?

ACCEPTABILITY:

* What are benefits for health care providers working at the Co-op model?
  for H.C. providers working in the community?
* Do local physicians accept? Why or why not?
* What response has the service received from other allied health professionals?
* Has any particular group facilitated the acceptance of the service in the community?
* What is the organizational structure of the Co-op model?

INCENTIVES / DISINCENTIVES:

* Economic incentives?
  disincentives?
* Political costs/benefits?
* Public's perception of incentives/disincentives?

FUTURE DIRECTIONS:

* What do you think Co-op/consumer sponsored health care services will look like over the next 5-10 years?
* What changes are needed if the scope and role of Co-op models are to be enhanced/expanded?

APPENDIX B

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